

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

31105

NOV 26 1927

**PLACE OF DEATH**

County Peru Registration District No. 637  
 Township Caruthersville Primary Registration District No. 4388  
 City Caruthersville (No. ....) St. .... Ward)

File No. ....  
 Registered No. 157  
 St. .... Ward)

**2. FULL NAME**

Sarah Frances Powers  
 (a) Residence. No. .... St. .... Ward. ....  
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8-16-1852

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .... hrs. or .... min.  
75 | 2 | 15

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work if work  
 (b) General nature of industry, business, or establishment in which employed (or employer).....  
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) Ky.  
 (STATE OR COUNTRY)

10. NAME OF FATHER Geo Ray

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ky.  
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Esther C. Crabtree

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ky.  
 (STATE OR COUNTRY)

14. INFORMANT Cora J. Muth  
 (Address) Sikeston, Mo

15. FILED Nov 1 27 Ada Martin  
 REGISTRAR

**1 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-31-1927

17. I HEREBY CERTIFY, That I attended deceased from Oct-31-1927 to Oct-31-1927  
 that I last saw him alive on Oct-31-1927, and that death occurred, on the date stated above, at 5 P m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Chronic Volvular Heart Disease

92A (duration) yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY) J.M.  
 (duration) yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED.....  
 IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....  
 WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....  
 (Signed) W. Spelty

11-1-27 (Address) North Office  
 \*State the DISEASE CAUSING DEATH, or if death from MOLEST CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Sikeston, Mo DATE OF BURIAL 11-2-27

20. UNDERTAKER J. J. Smith ADDRESS Caruthersville

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PARENTS

