

N. B.—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.

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

Do not use this space.

846

1. PLACE OF DEATH

County Henry
Township
City Windsor

Registration District No. 14
Primary Registration District No. 4214

File No.
Registered No. 2
St. Ward

2. FULL NAME

Sarah Green

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 25 - 1851

7. AGE YEARS MONTHS DAYS IF LESS THAN 1 day, hrs. or min.
76 | 11 | 8

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wicks Co. Mo.

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT C. V. Green
(Address) Windsor Mo.

15. FILED Jan 19 1928
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 18 1928

17. I HEREBY CERTIFY that I attended deceased from Jan 18 1928 to Jan 18 1928 that I last saw k. alive on Jan 18 1928, and that death occurred, on the date stated above, at Windsor Mo.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Interstitial Nephritis
Don't know (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) Heart of ship (duration) yrs. mos. da.

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

0 DID AN OPERATION PRECEDE DEATH? No DATE OF.....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Urinal
(Signed) T. J. Jensen M. D.
Windsor
Jan 19 1928 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Windsor Mo. DATE OF BURIAL Jan 19 1928

20. UNDERTAKER W. E. Austin ADDRESS Windsor Mo.

PHYSICIAN should
be very imprecise.

could be
Ex

Every item of info. should be carefully
checked, so that it may be
CAUSE OF DEATH in by

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Henry Registration District No. 14 File No.
 Township Primary Registration District No. 4214 Registered No.
 City Winkleville (No.) St. Ward

2. FULL NAME Sarah Green

(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 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT

(Address)
 FILED 3-8 2011 J. Leming
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 18 1928

17. I HEREBY CERTIFY That I attended deceased from 19..... to 19.....
 that I last saw h..... alive on 19....., and that death occurred, on the date stated above..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Intermittent Respiritis
 CONTRIBUTORY Fracture of Hip Fall
on porch
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed), M. D.
 , 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

N. ... supplied. AGE sh... stated EXACTLY. PHYSICIAN... if state ... no properly classified. Exact statement of OCCUPATION is v... important. REGISTRATION SHALL NOT BE RECEIVED FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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