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.

File No. 25457
Registered No. 270

1. PLACE OF DEATH

County ..... Registration District No. 791
Township ..... Primary Registration District No. 1003
City Kansas City (No. ..... St. ..... Ward)

2. FULL NAME 1599 Sarah Rogue Moon

(a) Residence. No. 4376 Cute Brilliant Ward. 11
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 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)
Female	White	Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 26 - 82

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	57	4	14	

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTY) Texas

PARENTS
10. NAME OF FATHER Calvin Hall
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTY) Unknown
12. MAIDEN NAME OF MOTHER Susan Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

Hospital Information

14. INFORMANT O Kavan
(Address) City Hospital

15. FILED 12 ..... 19 ..... Nat C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 10 1928

17. I HEREBY CERTIFY, That I attended deceased from Feb 18 1928, to July 10 1928, that I last saw her alive on July 10 1928, and that death occurred, on the date stated above, at 12:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis, chr Pulmon
2 / 22 F
3 / 25
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Tuberculous Peritonitis
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED ?
IF NOT AT PLACE OF DEATH?
0 DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? refused
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) Edward Helbing M. D.
, 19 28 (Address) City Hospital

*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
Lenexa Kans	7-16- 1928

20. UNDERTAKER W S Wade Mgr Funeral ADDRESS 4202

Roquemon