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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. 791 1003 File No. 25539

Township..... Primary Registration District No..... Registered No. 1334

City St. Louis Mo (No. St. Mary's Infirmary St. ..... Ward)

2. FULL NAME Sarah Anna Hart

(a) Residence. No. 2212 Salisbury St., 20 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*)
Female	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 10 - 1866

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	62	5	3	

8. OCCUPATION OF DECEASED 127 70
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

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

PARENTS

10. NAME OF FATHER Geo. Vaughn

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

12. MAIDEN NAME OF MOTHER Dont know

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

14. INFORMANT William B. Hart
(Address) 2212 Salisbury St

15. FILED JUL 16 1928 Alex C. Starkloff REGISTRAR

2

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/13 1928

17. I HEREBY CERTIFY, That I attended deceased from 6/20, 1928, to 7/13, 1928 that I last saw h. alive on 7/13, 1928 and that death occurred, on the date stated above, at 8 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Purpura hemorrhagica
13 | 0 4 B
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Gall bladder disease
Chronic Cholecystitis (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? No
WHAT TEST CONFIRMED DIAGNOSIS? Physical Exam.
(Signed) Lawrence W. Galle, M. D
, 19 (Address) 1536 Papin.

*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, CREATION, OR REMOVAL Calvary | DATE OF BURIAL July 17 1928

20. UNDERTAKER Ky Leidner Und Co. | ADDRESS 1417 N Market St Lo

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD