

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

Do not use this space.

36387

1. PLACE OF DEATH

County Clark
Township.....
City Kahoka (No.....)

Registration District No. 190
Primary Registration District No. 4113

File No.....
Registered No. 47 St. Ward)

2. FULL NAME Sarah Ellen Stevenson

(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 W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. If MARRIED, WIDOWED, OR DIVORCED, HUSBAND OR (OR) WIFE OF Alfred P. Stevenson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 11, 1848

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or ... min.
81 1 11

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

9. BIRTHPLACE (CITY OR TOWN) Uniontown,
(STATE OR COUNTRY) Pennsylvania

10. NAME OF FATHER Mrs. A. Gardner

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

12. MAIDEN NAME OF MOTHER Katherine Moore

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

14. INFORMANT Joseph Stevenson
(Address) Kahoka Mo.

15. FILED 11/23/28 J. Briggs REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 22, 1928

17. I HEREBY CERTIFY That I attended deceased from Nov 1 1928 to Nov 22 1928
that I last saw h..... alive on..... 19..... and that death occurred, on the date stated above, at 4:30 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Nephritis
Arterial Sclerosis 1311
.....
(duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) 1290
(duration) yrs. mos. da.

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

19. DID AN OPERATION PRECEDE DEATH..... DATE OF.....

20. WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....
(Signed) J. Briggs M. D.
11/23, 1928 (Address) Kahoka Mo

*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 Honey Creek Cem DATE OF BURIAL 11/23 1928

20. UNDERTAKER Fred Karle ADDRESS Kahoka Mo.

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.

g. R. B.

1928

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PHYSICIAN
CERTIFICATION

DATE OF EXAMINATION
AT PLACE OF EXAMINATION

104

**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 Clark
Township Hahoka
City Hahoka (No. St. Ward)

Registration District No. 190
Primary Registration District No. 4113

File No.
Registered No. 47

2. FULL NAME

(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.

Sarah Ellen Stevenson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 11 - 1848

7. AGE YEARS MONTHS DAYS
80 1 11
If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. da.
(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)

15. FILED 12 29 19 1929 R. Bridges REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 22 - 1928

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

18. WHERE WAS DISEASE CONTRACTED (duration) yrs. mos. da.
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)

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)

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

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

AMS should state exact date of death. Exact statement of OCCUPATION is very important. AGE should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important.

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