

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

Do not use this space.

1846

1. PLACE OF DEATH

County Jackson County
Towashin Kan.
City Kansas City, Mo. (No. 1002)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 430
St. _____ Ward _____

2. FULL NAME

Corneilia Bell Sabin
(a) Residence. No. Liberty, Mo. St. _____ Ward _____
(Usual place of abode)

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 11 1900

7. AGE YEARS MONTHS DAYS 19 6 16 If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Nursing
(b) General nature of industry, business, or establishment in which employed (or employer) Hospital
(c) Name of employer St. Louis Hospital

9. BIRTHPLACE (CITY OR TOWN) Liberty, Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER W. F. Sabin

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT D. J. Sabin
(Address) Liberty, Mo.

15. FILED 1-28-29 W. M. Crum REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 27 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1929, to Jan 27, 1929, that I last saw him alive on Jan 26-1929, and that death occurred, on the date stated above, at 1:40 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Septicemic meningitis
89/2
79A (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY acute septicemia waited
(SECONDARY) (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED St. Louis Hospital
IF NOT AT PLACE OF DEATH, _____
DID AN OPERATION PRECEDE DEATH? yes DATE OF 1-21-29

WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS Bacteriologic
(Signed) J. M. Crum M. D.
1-28-29 (Address) K. C. Mo.

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Liberty, Mo. DATE OF BURIAL Nov. 27 1929

20. UNDERTAKER Hill Undertaking Co. ADDRESS Liberty, 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.

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