

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

Do not use this space.

4905

1. PLACE OF DEATH

County Saline
Township Marshall
City Marshall

Registration District No. 796
Primary Registration District No. 30.38

File No. _____
Registered No. 19
St. _____ Ward) _____

2. FULL NAME

Sarah Bell Jamison

(a) Residence. No. _____ St. _____ Ward. _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE white 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) Mar. 14 1855

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
73 10 2

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) Saline Co Mo.

10. NAME OF FATHER

James N. Jamison

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Virginia

12. MAIDEN NAME OF MOTHER

Edimona Huston

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Saline Co Mo.

14.

INFORMANT Mrs Mary Davis
(Address) Marshall Mo

15.

FILED 1-23, 1929 Mrs John H. McQuire
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Jan 16, 1929, to Jan 16, 1929, that I last saw him alive on Jan 16, 1929, and that death occurred, on the date stated above, at 1:50 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

950
HB Myocarditis
(duration) _____ yrs. _____ mos. 304 ds.

CONTRIBUTORY (SECONDARY)

In pneumonia
(duration) _____ yrs. _____ mos. 25 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH Home

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical

(Signed) Geo S Hardin, M. D.

, 19 (Address) Marshall 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

DATE OF BURIAL

Arrow Rock

Jan. 18 1929

20. UNDERTAKER

L. R. Vandiner

ADDRESS

Marshall 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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