

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

Do not use this space.

6734  
900

**1. PLACE OF DEATH**

County Jackson  
Township Raw  
City N. G. Mo

Registration District No. 399  
Primary Registration District No. 1002

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Mary Jane Sawyer  
(a) Residence. No. 4207 Windsor St., Windsor Ward.  
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Widow of Mrs Sawyer

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 24th 1848

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
80 5 24

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work House work  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Memphis  
(STATE OR COUNTRY) Tenn

10. NAME OF FATHER Tom Robinson

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

12. MAIDEN NAME OF MOTHER Olga Murphy

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

14. INFORMANT Dr Tom Sawyer  
(Address) 1701 Jackson

15. FILED 2/23 29 Dr M. C. Connor  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 18 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb 19, 1929 to Feb 20, 1929 that I last saw him alive on Feb 24, 1929 and that death occurred, on the date stated above, at 5:30 m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Cardiac Asthenia

920  
1130  
162 (duration) yrs. mos. 1 ds.

CONTRIBUTORY (SECONDARY) Acute Gastritis & Emphysema

(duration) yrs. mos. 2 ds.

**18. WHERE WAS DISEASE CONTRACTED?**

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical exam

(Signed) John R Robinson, M. D.

2-20 1929 (Address) 610 Altman Bldg

\*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 Wash Washington DATE OF BURIAL Feb 23 1929

20. UNDERTAKER Rose & Henderson ADDRESS 15th Jackson

WRITE FAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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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