

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

Do not use this space.

6837

1. PLACE OF DEATH Jackson County Kan Registration District No. 399
 Township K.C. #4 Primary Registration District No. 1002
 City St. Louis (No. General Hospital #2) St. _____ Ward _____
 2. FULL NAME Saborn, Bertha Ella
 (a) Residence. No. 3301 Oakley St. 14 Ward. _____
 (Usual place of abode) _____ (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. 2 mos. _____ ds. _____ How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Colored 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) Dec 24 1928
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hr. or _____ min.
2 1 23

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

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

10. NAME OF FATHER Saborn Walter
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ark
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Smith Sarah
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ark
 (STATE OR COUNTRY)

14. INFORMANT Mother Sarah Saborn
 (Address) 3301 Oakley

15. FILED 7/28 29 M. M. Corrine
 REGISTRAR Corrine

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-17 1929
 17. I HEREBY CERTIFY, That I attended deceased from 2 16 1929, to 2-17 1929 that I last saw her alive on 2-17 1929, and that death occurred, on the date stated above, at 11:25 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ananition

15B
 (duration) yrs. 1 mos. _____ ds. _____
 CONTRIBUTORY (SECONDARY) Malnutrition
 (duration) yrs. _____ mos. _____ ds. _____

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH Home
 DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) Howard J. Smith, M. D.
2/18, 1929 (Address) Old City, 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 Woods Cemetery
 DATE OF BURIAL 3/4 1929

20. UNDERTAKER West, Appleton & Jones
 ADDRESS 1600 E. 19th

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

