

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

Do not use this space.

7583

1. PLACE OF DEATH *Pike*
 County *Pike* Registration District No. *609*
 Township *Louisiana* Primary Registration District No. *3032*
 City *Louisiana* (No. *907 Ohio*) *Ohio* St. *3* Ward
 Registered No.
 2. FULL NAME *Sarah Ann Maxley*
 (a) Residence No. *907 Ohio St* St. *B* 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *Black* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *King Maxley*
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) *3-6-60*
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
68 | 11 | 20

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) *Lincoln Co Mo*
 (STATE OR COUNTRY)

10. NAME OF FATHER *Edd Sidney*

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

12. MAIDEN NAME OF MOTHER *Margaret Wright*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Lincoln Co Mo*
 (STATE OR COUNTRY)

14. INFORMANT *King Maxley*
 (Address) *Louisiana Mo*

15. FILED *7/27/29* *J. H. Hays* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *2-26 1929*
 17. I HEREBY CERTIFY That I attended deceased from *2-24*, 19*29*, to *2-26*, 19*29*, that I last saw *her* alive on *2-26*, 19*29*, and that death occurred, on the date stated above, at *1045p* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage

CONTRIBUTORY (SECONDARY) *440*
 (duration) yrs. mos. ds.

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

Did an OPERATION PRECEDE DEATH? *No*. DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical*
 (Signed) *J. H. Hays*, M. D.
 7/27/29 (Address) *Louisiana 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 *Riverview Louisiana Mo* DATE OF BURIAL *2/28 1929*

20. UNDERTAKER *J. H. Hays* ADDRESS *Louisiana*

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.

MAR 25 1929

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