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

Do not use this space.

13389

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis (No. 3216½ Franklin St. ..... Ward)

File No. .....

Registered No. 3982

2. FULL NAME Sarah Dickson Leonard

(a) Residence. No. 3216½ Franklin St., 21 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: Colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 5-1849

7. AGE: 80 Years — Months — Days 26 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

234

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mississippi

2

PARENTS

10. NAME OF FATHER: Unknown

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

31

12. MAIDEN NAME OF MOTHER: Unknown

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

31

14. INFORMANT: Richard Dickson
(Address) 3216½ Franklin

15. FILED ..... 19 ..... Max C. Starkey, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 31 1929

17. I HEREBY CERTIFY, That I attended deceased from March 3, 1929, to March 31, 1929 that I last saw her alive on March 31, 1929, and that death occurred, on the date stated above, at 10 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Nephritis

131

.93C

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY) Chronic Myocarditis

(duration) 1 yrs. 6 mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? Not known.

DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Erskine D. Johnson, M. D

, 19 (Address) 3100 Lucas Ave.

*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: St. Peters

DATE OF BURIAL: 4/3 1929

20. UNDERTAKER: C W Roberts Undo

ADDRESS: 3035 Lucas

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.

...ONLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD