

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

Do not use this space.

13512

1. PLACE OF DEATH

County Shelby
Township Clay
City Clarence (No. _____)

Registration District No. 827
Primary Registration District No. 4500

File No. _____
Registered No. 7 St. _____ Ward _____

2. FULL NAME

Mrs Sarah Ann Clark
(a) Residence. No. _____ St. _____ 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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widow</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>July 3 1851</u>				
7. AGE	YEARS <u>78</u>	MONTHS <u>1</u>	DAYS <u>15</u>	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____				
9. BIRTHPLACE (CITY OR TOWN) <u>Kentucky</u> (STATE OR COUNTRY)				
PARENTS	10. NAME OF FATHER <u>Michael O'Hare</u>			
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Ireland</u> (STATE OR COUNTRY)			
	12. MAIDEN NAME OF MOTHER _____			
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY)			

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Mar 15 1929 to Mar 18 1929 that I last saw him alive on Mar 18 1929 and that death occurred, on the date stated above, at 9.10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Fall - Injuring hip
18 1/2 (duration) yrs. 1 mos. ds.
CONTRIBUTORY (SECONDARY) Senility 10
(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? No
WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) Frank K. Roy, M. D.
3/19 1929 (Address) Clarence, 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.

14. INFORMANT Mrs G. C. Palmer
(Address) Clarence Mo

15. FILED 3/20 1929 Roy Hamilton
REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Maplewood Cemetery DATE OF BURIAL 3-21 1929

20. UNDERTAKER Hamilton Und. Co ADDRESS Clarence Mo

WRITE PLAINLY, 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

MAY 2

1929

23

31

