

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

Do not use this space.

18563

1. PLACE OF DEATH

County Jefferson
Township Loachia
City Festus (No. St. Ward)

Registration District No. 431
Primary Registration District No. 4349

File No.
Registered No. 64

2. FULL NAME Sarah A. Clark

(a) Residence. No. St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

F. O. Clark

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 13, 1833

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
96 6 20

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) General Housework
(c) Name of employer Self

9. BIRTHPLACE (CITY OR TOWN) Kent County
(STATE OR COUNTRY) Delaware

10. NAME OF FATHER E. Beckett
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Unknown

14. INFORMANT J. B. Clark
(Address) Festus Mo.

15. FILED 5/7, 1929 J. E. Rutledge REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 30 1929

17. I HEREBY CERTIFY, That I attended deceased from April 6th 1929 to May 30 1929 that I last saw h. alive on May 30 1929 and that death occurred, on the date stated above, at 7:51 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Paternal Regurgitation
Anterior Sclerosis
Unknown (duration) yrs. mos. ds.

CONTRIBUTORY Senile Gangrene left foot
(SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

2. DID AN OPERATION PRECEDE DEATH? 1 DATE OF April 26th
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) H. G. Smith M. D.
, 19 (Address) Festus 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 Bellshoro Mo DATE OF BURIAL May 6 1929

20. UNDERTAKER Quester + Vineyard ADDRESS Festus Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN 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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