

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

Do not use this space.

19867

1. PLACE OF DEATH

County.....
Township.....
City *St Louis Mo* (No. *1425*)

Registration District No. *791*
Primary Registration District No. *1003*
Angelica St

File No.....
Registered No. *5488*
St..... Ward.....

2. FULL NAME

Sarah F McLaughlin
(a) Residence. No. St. *26* Ward.....
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 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) *May 12th 1855*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
74 *5*

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER *William Watkins*

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

12. MAIDEN NAME OF MOTHER *Louisa Erwin*

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

14. INFORMANT *Henry P Cotner*
(Address) *1425 Angelica St*

15. FILED *MAY 18 1929*
REGISTRAR *Wm C Stanley*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 17* 19 *29*

17. I HEREBY CERTIFY, That I attended deceased from *May 16th* 19 *29* to *May 17* 19 *29* that I last saw her alive on *May 16th* 19 *29* and that death occurred, on the date stated above, at *11:20 A.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute Bronchitis non Tubercular
131 (duration) yrs. mos. *5* ds.
10 to 14 CONTRIBUTORY *chronic nephritis*
(SECONDARY) (duration) yrs. *6* mos. ds.

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

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

20. WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *chronic*
(Signed) *Carl Orth* M. D.

May 18 19 *29* (Address) *1437 Pine*

*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 DATE OF BURIAL
Cape Girardeau Mo *May 20* 19 *29*

20. UNDERTAKER ADDRESS
Math Hermann & Son 216 1/2 Fair

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.

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