23731-b

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

Do not use this space.

23731-b

1. PLACE OF DEATH

County Barry — Registration District No. 29 — File No.

Township Flatcreek — Primary Registration District No. 5038 — Registered No. 53

City Cassville (No. ..., ... St. ..... Ward)

2. FULL NAME Sarah Shrum

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Fe	wh	Widow

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
about 79 yrs				

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(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) Barry Co Mo.

PARENTS

10. NAME OF FATHER John Skelton

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

12. MAIDEN NAME OF MOTHER Elizabeth Skelton

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

14. INFORMANT Mr. Sennell (Address) Cassville

15. FILED Nov 1, 1929 Mrs H. R. Williams Dpt. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-27- 1929

17. I HEREBY CERTIFY, That I attended deceased from 6-1- 1929, to 7-27 1929 that I last saw h. w alive on 7-26 1929, and that death occurred, on the date stated above, at 5 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Anemia, Senile
Brights Disease
1 Sk B
1 Sk B
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) age
(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? Clinical

(Signed) [signature], M. D.
1, 19 (Address)

*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
Muncey	7-28 1929
20. UNDERTAKER	ADDRESS
Horine Funeral Service	Cassville Mo

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.

...WITH UPRADING INK—THIS IS A PERMANENT RECORD