

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

Do not use this space.

32869

1. PLACE OF DEATH

County Andrew
Township
City Amazonia, (No. Amazonia, Mo.)

Registration District No. 8
Primary Registration District No. 4000-

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

2. FULL NAME Sarah Harmon,

(a) Residence No. Amazonia, Mo. St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 16 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married,

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan'y. 27, 1892

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	37	8	24	

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) Andrew County,
(STATE OR COUNTRY) Missouri,

10. NAME OF FATHER Joseph Milbourn,

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Andrew Co.,
(STATE OR COUNTRY) Missouri,

12. MAIDEN NAME OF MOTHER Laura Banning,

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

14. INFORMANT Thomas Harmon
(Address) Amazonia, Missouri,

15. FILED 10-23, 1929 J. W. Holcomb
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Oct. 27, 1929, to Oct. 29, 1929 that I last saw him alive on Oct. 29, 1929, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Rupture of blood vessel
(Hemorrhage internal)

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

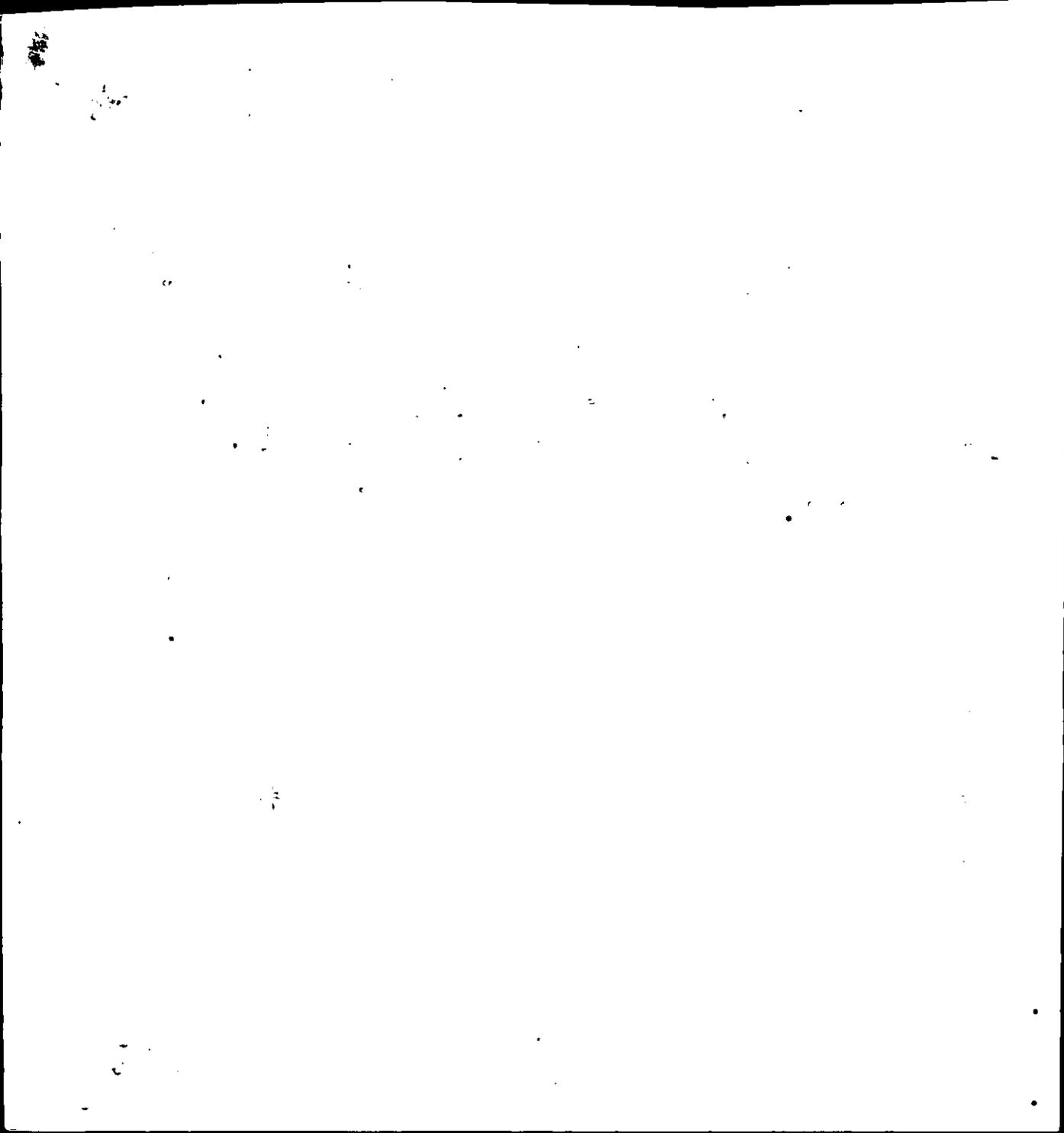
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) S. J. Brown, M. D.
, 19 _____ (Address) Amazonia 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 Amazonia, Missouri, DATE OF BURIAL Oct. 23, 1929

20. UNDERTAKER J. A. B. ... ADDRESS 319 S. 10 St.



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Andrew Registration District No. 8 File No. _____
 Township _____ Primary Registration District No. 4003 Registered No. _____
 City Amazonia (No. _____) St. _____ Ward _____

2. FULL NAME

Sarah Harmon
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State) 29
 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>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>M</u>
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.	
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)

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

14. INFORMANT (Address)

15. FILED 10-23, 1919 J. W. Holcomb REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 21 1919

17. I HEREBY CERTIFY That I attended deceased from _____ 19____ to _____ 19____ that I last saw h. _____ alive on _____ 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Ruptured blood vessel
in stomach, by
person then 10 yrs.
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) _____, M. D.
 _____, 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 _____ 19____

20. UNDERTAKER ADDRESS _____

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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