

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

Do not use this space.

33848

1. PLACE OF DEATH

County Jackson
Township Raw
City H.C. (No. Research)

Registration District No. 399
Primary Registration District No. 2002

File No. 4350
Registered No. 2002
St. _____ Ward _____

2. FULL NAME

Mrs Sarah M. Hill

(a) Residence No. 6641 E. 15th St., _____ 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) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF M^r & K^{ate} Hill

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 14, 1851

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, _____ hrs. or _____ min.
	77	10	2	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work retired
(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) Ohio

10. NAME OF FATHER Robt. Sage

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) No not know

12. MAIDEN NAME OF MOTHER No not know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Do not know

14. INFORMANT Mrs. B. H. Adams

(Address) 6641 E. 15th St.

15. FILED 10/17/1929 M. M. Crowe REGISTRAR
asst.

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from 14 Oct. 1929, to 19 Oct. 1929, and that I last saw h. e. r. alive on 16 Oct. 1929, and that death occurred, on the date stated above, at 7:15 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia double lobar
Pulmonary edema
59

108 (duration) yrs. mos. ds. 2 ds.
1115 Diabetes, Diabetic gangrene
CONTRIBUTORY (SECONDARY) int. organ

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH Rosebud Hospital

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

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Fat.
(Signed) Donald K. Black, M. D.

Oct. 17, 1929 (Address) 743 Lathrop Bldg.

*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

Mt. Moriah DATE OF BURIAL Oct. 18, 1929

20. UNDERTAKER

C. H. Blackburn & Son ADDRESS 2825 Indef. Blvd.

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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790 1000