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

Do not use this space. 33878

4330

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No.
Township Kaw — Primary Registration District No. 1002 — Registered No.
City Kansas Mo (No. 921-E 4th St St. Ward)

2. FULL NAME Sarrah Grant
(a) Residence. No. 921-E 4th St., 1 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)
Female	Col.	Widowed

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
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8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laundress
(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

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Dont Not Know
12. MAIDEN NAME OF MOTHER Harrett payne
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Dont Not Know

14. INFORMANT Author Grant.
(Address) 921 E 4th St

15. FILED 10/19, 1929 M. M Crowe REGISTRAR
ass'l

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 17th 1929

17. I HEREBY CERTIFY, That I attended deceased from Oct 6th Oct 6th, 1929, to Oct. 16, 1929 that I last saw her alive on Oct. 16, 1929, and that death occurred, on the date stated above, at 4 o'clock a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Malaria Fever and Heart and Kidney insufficiency
38
45B
133C
(duration) yrs. mos. 10 ds.

CONTRIBUTORY (SECONDARY) as above stated
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH was contracted at Home
DID AN OPERATION PRECEDE DEATH? no DATE OF X
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? General Symptoms
(Signed) Alexander Falconer M. D.
10/17, 1929 (Address) 205½ Westport ave

*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
Marshall Mo	10th-20th 1929
20. UNDERTAKER	ADDRESS
West Appleton & Jones	1600 E 19

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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