

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

Do not use this space.

33998
4451

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Jackson Primary Registration District No. _____
 City K. C. Mo. (No. 714 Washington St.) St. _____ Ward _____

File No. _____
 Registered No. _____

2. FULL NAME

Sarah Leathryn Sanders
 (a) Residence. No. 714 Wash. 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 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 James H. Sanders
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar-20-1854
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
75 7 7

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work none
 (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) Kentucky

10. NAME OF FATHER Wm Bruce

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

12. MAIDEN NAME OF MOTHER No Record

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

14. INFORMANT W. B. Sanders
 (Address) 714 Washington Ave

15. FILED 10 28 1929 M. M. Chowe
 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 27 1929 that I last saw h. alive on 10 27 1929, and that death occurred, on the date stated above, at 2:30 pm m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
930

CONTRIBUTORY (SECONDARY) Myocardial Infarct
 (duration) 2 yrs. 2 mos. 12 ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? none

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) J. Walcott M. D.
1029 1929 (Address) Kansas City 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 Highland Park DATE OF BURIAL 10-29-29

20. UNDERTAKER Mrs. C. L. Foster ADDRESS K. C. Mo.

WRITE FAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

V. U. NO. 2.

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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125.7
vie 886