

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

Do not use this space.

37223

1. PLACE OF DEATH
 County Jackson Registration District No. 399
 Township Kaw Primary Registration District No. 002
 City R. e. mo. (No. 0222 Megee) St. _____ Ward _____

2. FULL NAME Sarah M Sturgeon
 (a) Residence. No. 0222 Megee St. 8 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.

File No. _____
 Registered No. 40033

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 12 - 1845

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
84 10 3

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) Ind
 (STATE OR COUNTRY)

10. NAME OF FATHER Wm R Mackland

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

12. MAIDEN NAME OF MOTHER Harper

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

14. INFORMANT Mrs W J Allen
 (Address) 21619 E 10th

15. FILED 11/15 29 M. M. Connor
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11/15 1929

17. I HEREBY CERTIFY, That I attended deceased from Oct 9 1928, to Nov 15 1929 that I last saw him alive on Nov 15 1928, and that death occurred, on the date stated above, at 11:25 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

101 Old Age

 _____ (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) High Blood Pressure
Chronic Nephritis (duration) 15 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? no

WHAT TEST CONFIRMED DIAGNOSIS Symptoms & physical Ex.
 (Signed) Geo A Drall M. D.

11/15 1929 (Address) 838 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 Wodge City Mo. DATE OF BURIAL 11/16 1929

20. UNDERTAKER O V Mast ADDRESS 1915 E 15

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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