

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

Do not use this space.

41325

1. PLACE OF DEATH

County Livingston Registration District No. 508
Township _____ Primary Registration District No. 30-26
City Chillicothe (No. _____) St. _____ Ward _____

File No. _____
Registered No. 121

2. FULL NAME

Mrs Sarah Jane Walker
(a) Residence, No. _____ St. _____ 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 _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 3 1849

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>80</u>	<u>8</u>	<u>14</u>	<u>87 19</u>

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)

(STATE OR COUNTRY) Jackson Twp Mo

10. NAME OF FATHER

John Hawkins

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Lancaster Mo

12. MAIDEN NAME OF MOTHER

Mrs Mary Semmes

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) North. Flk

14. INFORMANT

Chas Walker
(Address) Chillicothe Mo

15. FILED

12/19 1929
Seulien Barney
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Dec 16, 1929, to Dec 17, 1929, that I last saw her alive on Dec 17, 1929, and that death occurred, on the date stated above, at 10.40 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral hemorrhage
87 19
(duration) _____ yrs. _____ mos. 9 ds.

CONTRIBUTORY (SECONDARY)

arterio-sclerosis
(duration) 5 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Physical exam

(Signed) H. M. Russell, Jr. M. D.

Dec 19 1929 (Address) Chillicothe 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

DATE OF BURIAL

Mt Olive Cemt. 12-19 1929

20. UNDERTAKER

ADDRESS

F. B. Norman Chillicothe

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

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.

1929

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