

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

Do not use this space.

489

1. PLACE OF DEATH

County Cedar
Township Jefferson
City (No.)

Registration District No. 163
Primary Registration District No. 5230

File No.
Registered No. 5

2. FULL NAME Sarah Jane Ganaway

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Robert Gregory Ganaway</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Mar 5-1857</u>		
7. AGE	YEARS <u>72</u>	MONTHS <u>9</u>
	DAYS <u>26</u>	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
(c) Name of employer		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 1 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov 12 1929 to Jan 1 1930 that I last saw her alive on Dec 26 1929 and that death occurred, on the date stated above, at 3:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Septis

CONTRIBUTORY (SECONDARY)

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? clinical
(Signed) R. O. Newsoms, M. D.

*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.

9. BIRTHPLACE (CITY OR TOWN) don't know (STATE OR COUNTRY)

10. NAME OF FATHER Joseph Kennon

11. BIRTHPLACE OF FATHER (CITY OR TOWN) don't know (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mary Fox

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) don't know (STATE OR COUNTRY)

14. INFORMANT Allen Ganaway (Address) Sumner Mo

15. FILED Jan. 30 E. S. Smith REGISTRAR
Mary Bayless

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Alder Cemetery DATE OF BURIAL Jan 2 1930

20. UNDERTAKER none ADDRESS

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.

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STATE
of New York

County of ...

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Cedar Registration District No. 165 File No. _____
 Township Jefferson Primary Registration District No. 5-230 Registered No. 3
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Sarah Jane Garaway
 (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. _____

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work _____
 (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) _____

10. NAME OF FATHER _____
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER _____
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

14. INFORMANT (Address) _____

15. Filed Feb. 19 30 Ed S. Smith REGISTRAR
Mary Boylston

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 1 19 30
 17. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____ that I last saw him _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Heart failure - due to sticking thumb with safety pin in thumb then callulosis of arm
 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) _____ (duration) 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? _____
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) _____, M. D.
 _____, 19 (Address) _____

*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 _____ 19 _____

20. UNDERTAKER _____ ADDRESS _____

E PLAINLY WITH C K---THIS IS A PERMANENT RECORD

N. B.—Every bit 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

1593

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