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

Do not use this space.

791 2663

1. PLACE OF DEATH

County ..... Registration District No. 1003 File No. 91

Township ..... Primary Registration District No. ..... Registered No. .....

City St Louis (No. City Hospital St. ..... Ward)

2. FULL NAME Sarah Caroline Blackburn

(a) Residence. No. 910 Julia St., 23 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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	White	Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 8 1881

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	48	6	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Press feeder
(b) General nature of industry, business, or establishment in which employed (or employer) Printing
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY) Mo

PARENTS
10. NAME OF FATHER Eli Chase
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Ellen Conn
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Ky

14. INFORMANT Lucille Blackburn
(Address) 910 Julia St

15. FILED JAN - 4 1930 19 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 2 1930

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 11 30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
General Carcinomatosis
Chronic Myocarditis
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) (Left Breast)
(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? Yes
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) J. W. Kerner, M.D.
1/4, 1930 (Address) Dep. Coroner

*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
Valhalla	1-6 1930
20. UNDERTAKER	**ADDRESS**
Arthur J Donnelly	2039 Ward St

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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