MAR 25 1930

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

Do not use this space.

Dr Layer

File No. 4656

Registered No. 130

1. PLACE OF DEATH

County Greene

Township

City Springfield Mo. No. 0 1020 E Walnut St. Ward)

Registration District No. 318

Primary Registration District No. 2001

2. FULL NAME Sarah E Mcely

(a) Residence. No. 1020 E Walnut 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) May 18 - 1849

7. AGE 80 YEARS | MONTHS 8 | DAYS 21 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(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) Mo

PARENTS

10. NAME OF FATHER John Casberry

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

12. MAIDEN NAME OF MOTHER Amanda Mitchell

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

14. INFORMANT Dr F C Casberry
(Address) Springfield Mo

15. FILED 2-10, 1930 Lon Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 9 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to Feb 9, 1930 that I last saw her alive on Feb 9, 1930, and that death occurred, on the date stated above, at 9 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

12A Hemiplegia (probably)

12D Cerebral Hemorrhage

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (SECONDARY)

(duration) 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? Clinical

2-9 (Signed) J B Layer M.D.

(Address) 842 Medical Arts

*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 Aurora Mo

DATE OF BURIAL 2/9 1930

20. UNDERTAKER [illegible] ADDRESS Springfield Mo

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.

38
130