

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

Do not use this space.

5204 802

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Raw Primary Registration District No. Flora 1002
 City Flora, City Mo. (No. 3815) St. Flora (Ward)

File No. 5204 802
 Registered No. _____
 St. _____ Ward _____

2. FULL NAME

Mrs. Sophia Larson
 (a) Residence. No. 3815 St. Flora St. 13 Ward. _____
 (Usual place of abode) _____ (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. 15 mos. 8 ds. How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE Wh. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John Larson
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Febr. 2-1847
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
83 0 19
 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) Sweden
 (STATE OR COUNTRY) _____
 10. NAME OF FATHER Olaf Johnson
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Sweden
 (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER Hannah Johnson
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Sweden
 (STATE OR COUNTRY) _____

14. INFORMANT Mrs. James H. Anderson
 (Address) 3815 Flora
 15. FILED 7/24/30 M. M. Crowe
 asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Febr. 21 1930
 17. I HEREBY CERTIFY, That I attended deceased from her leg _____, 1929, to Febr. 21, 1930 that I last saw her alive on July 28, 1928, and that death occurred, on the date stated above, at 12:15 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arteriosclerosis
520 97 years
 CONTRIBUTORY Cancer Stomach (duration) _____ yrs. _____ mos. _____ ds.
 (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? none
 (Signed) J. H. Field M. D.
7/24/30 (Address) 728 Market 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 Edmwood DATE OF BURIAL 7/24 1930
 20. UNDERTAKER W. W. Newcomb's Sons ADDRESS A. C. Mo.

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