

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

Do not use this space.

6177

1. PLACE OF DEATH

County St. Francois Registration District No. 779
 Township Randolph Primary Registration District No. 6024a
 City Desloge (No. _____) St. _____ Ward _____

File No. _____
 Registered No. _____

2. FULL NAME Sarah Lucinda Alberts

(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) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John Alberts

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr. 5-1866

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
	<u>63</u>	<u>10</u>	<u>2</u>	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work House 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) St. Francois Co. Mo

10. NAME OF FATHER Samuel McHenry

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) St. Francois Co. Mo

12. MAIDEN NAME OF MOTHER Sarah Orter

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) St. Francois Co. Mo

14. INFORMANT John Alberts
 (Address) Farmington Mo. R. 4

15. FILED 2-9-30 R. B. Lester
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/7 1930

17. I HEREBY CERTIFY, That I attended deceased from 2/6 1930, to 2-7 1930, that I last saw him alive on 2-7 1930, and that death occurred, on the date stated above, at 2 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute dilatation of heart
92-A
95-1 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Chronic valvular heart disease & rheumatism yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) J. M. Feehan M. D.

2/8 1930 (Address) Desloge 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 McHenry Cemetery DATE OF BURIAL Feb. 9 1930

20. UNDERTAKER C. J. Boyer ADDRESS Desloge Mo

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.

233

