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

Do not use this space.

6503

1. PLACE OF DEATH

County ..... Registration District No. 791 ~~1003~~ File No. .....

Township ..... Primary Registration District No. ..... Registered No. 1317

City St Louis (No. 4270 Botanical Av St. ..... Ward)

2. FULL NAME Sarah Stanard Trattles

(a) Residence. No. 4270 Botanical Av St., 17 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF Edward C. Trattles

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 1 - 1857.

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ... hrs. or ..... min.
	72	5	6	

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

9. BIRTHPLACE (CITY OR TOWN) Cass. Co.
(STATE OR COUNTRY) Michigan

PARENTS

10. NAME OF FATHER Daniel Stanard

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

12. MAIDEN NAME OF MOTHER Lucinda Glass.

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

14. INFORMANT Lydia Coates.
(Address) 4270 Botanical.

15. FILED Feb - 7 1930 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Jan 27th 1930 to Feb. 7th 1930 that I last saw her alive on Feb 7th 1930 and that death occurred, on the date stated above, at 11.45 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Apoplexy
Hemorrhage
82A

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) [illegible] (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) Dlen D D Forman, M. D.

2/7/1930 (Address) 3900 Cleveland

*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
Porter, Mich	Feb 10 1930

20. UNDERTAKER	ADDRESS
Pietz Bros 3029	Lafayette Av

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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