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

Do not use this space.

7196

1. PLACE OF DEATH

County..... Registration District No. 791

Township..... Primary Registration District No. 203

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

File No. 1975

Registered No. .....

2. FULL NAME Sarah Satchwell

(a) Residence. No. 2739a Cass Ave St., 20 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 Hubert Satchwell

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown 1864

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
abt 66	unknown		

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) Illinois

PARENTS

10. NAME OF FATHER John Smith

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

12. MAIDEN NAME OF MOTHER Dont Know

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

14. INFORMANT Hubert Satchwell
(Address) 2739a Cass Ave

15. FILED ..... 19..... Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 24 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1929 to Feb. 24, 1930, that I last saw h. alive on Feb. 15, 1930 and that death occurred, on the date stated above, at 7.50 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer of uterus

(duration) 1 yrs. 6 mos. ..... ds.

CONTRIBUTORY (SECONDARY) chronic myocarditis

(duration) 1 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH 2739a Cass Ave

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Physical ex.

(Signed) D. H. Kilbing, M. D.

2/25, 1930 (Address) 4963 Fountain

*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 Calvary Cemetery — DATE OF BURIAL 2/26 1930

20. UNDERTAKER Arthur J Donnelly — ADDRESS 2039 Wash 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.

4963 Four [illegible]