

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

Do not use this space.

11937

1. PLACE OF DEATH

County... *Boone*
Township...
City... *Boone*

Registration District No. *125*
Primary Registration District No. *2009*
(No. *322* *Merrimeth*)

File No. _____
Registered No. *383*
St. _____ Ward) _____

2. FULL NAME

Sarah H. Jaynes

(a) Residence. No. *322 Merrimeth* 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. da. How long in U. S., if of foreign birth? yrs. mos. da.

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 _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Nov. 25-1857*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
72 5 4

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) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *New Albany Ind.*

10. NAME OF FATHER *John Rice*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *New Albany Ind.*

12. MAIDEN NAME OF MOTHER *Caroline Tucker*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Middle Tenn*

14. INFORMANT *A. L. Jaynes*
(Address) *Boone Missouri Mo.*

15. FILED *5/1 1930* *W. C. Thompson* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 29 1930*

17. I HEREBY CERTIFY, That I attended deceased from *Spk.* 1929, to *April 29*, 1930, that I last saw her alive on *April 29*, 1930, and that death occurred, on the date stated above, at *10:30* a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Uremic Poisoning
53 B
132 B

CONTRIBUTORY (SECONDARY) *Coronary bloods*
(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? *Lobley T. Ogden*
(Signed) *W. C. Thompson*, M. D.
, 19 *Boone Missouri 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 *Thebes Ill. Cemetery* DATE OF BURIAL *May 2, 1930*

20. UNDERTAKER *Walther Und. Co. Boone Mo.* ADDRESS _____

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.

STATE DEPARTMENT WITH ENCLAVING INFORMATION THIS IS A PERMANENT RECORD

JUL 5 1950