JUN 27 1930

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

Do not use this space.

17292

File No. .....

Registered No. 45

1. PLACE OF DEATH

County St Louis — Registration District No. 1160

Township Central — Primary Registration District No. 4470

City University City (No. 6600 Washington St. Ward)

2. FULL NAME Sarah Helena Hart

(a) Residence. No. 6600 Washington 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Robert Hart

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 10, 1844

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	85	4	26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Lexington
(STATE OR COUNTY) Mo.

PARENTS

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTY) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTY) Not Known

14. INFORMANT Frank A. Burgstedt
(Address) 1219 Shawnee Pl

15. FILED 5-8, 1930 Lena V. Moeller D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 6 1930

17. I HEREBY CERTIFY, That I attended deceased from May 2 —, 1930, to May 6 —, 1930 that I last saw h. alive on May 6 —, 1930, and that death occurred, on the date stated above, at 7:35 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hypostatic Pneumonia

111B

162

..... (duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (SECONDARY) Senility

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

18. WHERE WAS DISEASE CONTRACTED 103

IF NOT AT PLACE OF DEATH .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. Rhyne, M. D.

5-7-, 1930 (Address) 607 N. Grand Bl.

*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
Valhalla Cem	May 9 1930
20. UNDERTAKER	**ADDRESS**
Akron L & U Co.	2707 N Grand

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.