

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

Do not use this space.

19623

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Townshp Wagon Primary Registration District No. 1002
 City H. C. Mo. (No. 3428 Wyandotte)

File No. _____
 Registered No. 2624
 St. _____ Ward _____

2. FULL NAME Sarah C. Burton

(a) Residence. No. 3428 Wyandotte St. 5 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 Fe 4. COLOR OR RACE Wh. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 28-1883

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>77</u>	<u>1</u>	<u>26</u>	

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) Wagneboro Tenn.
 (STATE OR COUNTRY)

10. NAME OF FATHER no Records

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) no Record

12. MAIDEN NAME OF MOTHER no Record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) no record

14. INFORMANT Jos. J. Miller
 (Address) _____

15. FILED 6/24, 1936 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-24-1930

17. I HEREBY CERTIFY, That I attended deceased from June 19 1930 to June 24 1930
 that I last saw her alive on June 24, 1930, and that death occurred, on the date stated above, at 7:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Valvular Heart Disease

CONTRIBUTORY (SECONDARY) 924 900 (duration) 15 yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Symptoms
 (Signed) A. D. W. Munnich M. D.

6/24, 1930 (Address) 2327 Broad ave.

*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 6-26 1930

20. UNDERTAKER Mrs. C. L. Feate ADDRESS etc

K. 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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