

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

Do not use this space.

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**1. PLACE OF DEATH**

County.....  
Township *St. Louis*  
City..... (No. *615 Clara ave*)

Registration District No.....

Primary Registration District No.....

File No.....  
Registered No. *6356*  
St. .... Ward)

**2. FULL NAME**

*Sarah Adeline White*  
(a) Residence. No. *615 Clara St.* Ward. *5*  
(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 <i>Female White</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Widowed</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Wm Clarence White</i>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Sept 2, 1853</i>		
7. AGE <i>76</i>	YEARS <i>9</i>	MONTHS <i>27</i>
		DAYS <i>27</i>
		If LESS than 1 day, ..... hrs. or ..... min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <i>at Home</i> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

9. BIRTHPLACE (CITY OR TOWN) *Alton Illinois*  
(STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <i>John Gunn</i>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <i>New York</i>
	12. MAIDEN NAME OF MOTHER <i>Leah B. Roland</i>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <i>N. Y.</i>

14. INFORMANT *Leah C. White*  
(Address) *615 Clara*

15. FILED *Mar 21 1930*  
REGISTRAR *Wm O. Stankley*

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 29, 1930*  
17. I HEREBY CERTIFY, That I attended deceased from *June 27, 1930* to *June 29, 1930* that I last saw h. l. a. alive on *June 29, 1930* and that death occurred, on the date stated above, at *2:40 p. m.*

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*87A Cerebral Apoplexy*  
(duration) yrs. mos. ds. *21*  
CONTRIBUTORY (SECONDARY) *74 (6)*  
(duration) yrs. mos. ds.

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

8 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....  
WAS THERE AN AUTOPSY?.....  
WHAT TEST CONFIRMED DIAGNOSIS  
(Signed) *Nelson W. Hawley M. D.*  
*June 30, 1930* (Address) *5899 Delmar 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 *Valhalla Crematory* DATE OF BURIAL *July 1, 1930*

20. UNDERTAKER *Ch. Lupton* ADDRESS *Clared*

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS PERMANENT RECORD

