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

Do not use this space.

23170

399

1002

File No. .....

Registered No. 3165

1. PLACE OF DEATH

County Jackson

Township .....

City Kansas City (No. 2639 Forest St. .....Ward)

Registration District No. .....

Primary Registration District No. .....

2. FULL NAME Sarah E Haines

(a) Residence. No. 1418 N 25 St. Kansas Ward.

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 30 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 Alpheus M Haines

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mch 6 - 1857

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 73 | 4 | 23 | |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Practical Nurse

(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) Mo.

PARENTS

10. NAME OF FATHER Jno Langston

11. BIRTHPLACE OF FATHER (CITY OR TOWN) — —

(STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) — —

(STATE OR COUNTRY) Unknown

14. INFORMANT Jas. M. Haines

(Address) 1027 N Elmwood

15. FILED 7/31, 1930 M. M. Crowe asst. REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from July 27, 1930 to July 29, 1930 that I last saw her alive on July 28 - 1930 and that death occurred, on the date stated above, at 6.30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial Pneumonia

H.C.B.

107A

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (SECONDARY) Carcinoma of Stomach

(duration) 1 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? Clinical exam

(Signed) J. N. Hill M. D.

7/29, 1930 (Address) 1037 Winner Road Independence 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 Mt Hope Cem.

DATE OF BURIAL 7/31 1930

20. UNDERTAKER Porter Funeral

ADDRESS K.C. Kans

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.