SEP 22 1930

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

Do not use this space.

File No. 26071
Registered No. 53

1. PLACE OF DEATH
County: Cape
Township: Cape
City: Jackson (No. ..... St. ..... Ward)

Registration District No. 124
Primary Registration District No. 4070

2. FULL NAME: Sarah Adeline Seibert

(a) Residence. No. ..... 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: F
4. COLOR OR RACE: B
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Andrew Seibert

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan 21 - 1873

7. AGE: Years 57 | Months 6 | Days 27 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN): Jackson
(STATE OR COUNTRY): Mo

PARENTS
10. NAME OF FATHER: Forest Lacey
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Jackson
(STATE OR COUNTRY): Mo
12. MAIDEN NAME OF MOTHER: Lavenia Bell
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Jackson
(STATE OR COUNTRY): Mo

14. INFORMANT: Evelyn Seibert
(Address): Jackson Mo

15. FILED 8-22 1930 D. G. Seibert
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Aug 18 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1930, to Aug 18, 1930 that I last saw h. alive on Aug 10, 1930 and that death occurred, on the date stated above, at 8 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulm. Tuberculosis
(duration) 2 yrs. 1 mos. 10 ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) C. P. Johnson, M. D.
8-19, 1930 (Address) Jackson 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: Jackson City Cemetery
DATE OF BURIAL: Aug 21 1930

20. UNDERTAKER: Crocraft & Miller
ADDRESS: Jackson Mo

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.