

SEP 26 1930

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

Do not use this space.

27547

1. PLACE OF DEATH

County *Phelps*
Township *Rolla*
City (No. _____) _____ St. _____ Ward _____

Registration District No. *677*
Primary Registration District No. *4701 (5901)*

File No. _____
Registered No. *57*

2. FULL NAME

Sarah Jane Luster

(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 *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widowed*

5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) WIFE OF *Thomas B Luster*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Dec 12 1841*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
88 8 14

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) *at home*
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) *Warren Co MO*
(STATE OR COUNTRY)

10. NAME OF FATHER *Emsley Dourt*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Mo*
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Dourt Know*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Mo*
(STATE OR COUNTRY)

14. INFORMANT *Mrs Hancock*
(Address) *Rolla Mo*

15. FILED *Aug 27 1930* *Geo. F. Myers*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Aug 26 1930*

17. HEREBY CERTIFY That I attended deceased from *July 10 1930* to *Aug 26 1930*
(that I last saw him alive on *Aug 26 1930*, and that death occurred, on the date stated above, at *5:15* m.)

THE CAUSE OF DEATH* WAS AS FOLLOWS
Cholelithiasis

12 1/3
(duration) yrs. *1* mos. ds.

CONTRIBUTORY (SECONDARY) *none*
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *12/4/30*
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? *No* DATE OF _____

WAS THERE AN AUTOPSY? *No*

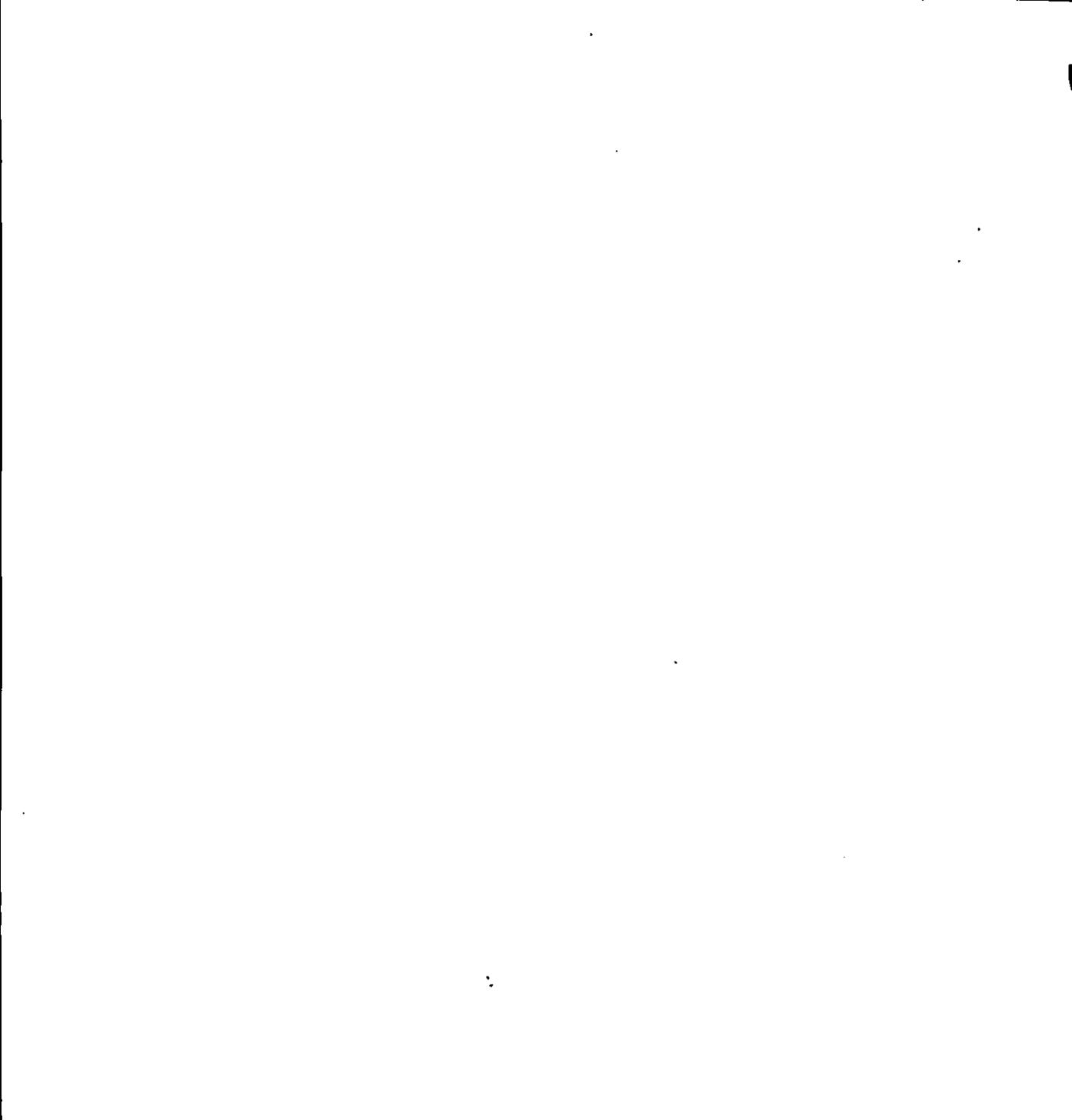
WHAT TEST CONFIRMED DIAGNOSIS *none*
(Signed) *R Mitchell* M. D.

, 19 (Address) *Rolla 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 _____ DATE OF BURIAL _____
19

20. UNDERTAKER _____ ADDRESS _____



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ALL INFORMATION COLLECTED
 FOR MUST BE WRITTEN ON
 THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Phillips Registration District No. 677 File No.
 Township Rolla Primary Registration District No. 5901 Registered No. 57
 City St. Ward

2. FULL NAME Sarah Jane Luster

(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 W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Wid

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

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

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (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)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED Oct 12 1930 Geo. F. Ayas REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 26 19 30

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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)....., M. D. , 19 (Address)

*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

Belle, Missouri | 8/27 1930
 20. UNDERTAKER | ADDRESS

Harry R. McCaw | Rolla, Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-27547