

OCT 29 1930

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

Do not use this space.

30339

1. PLACE OF DEATH

County *Greene*  
Township *Greene*  
City *Greene*

Registration District No. *444*  
Primary Registration District No. *5004*

File No. ....  
Registered No. *13* St. .... Ward)

2. FULL NAME

*Sarah Jane Northcraft*

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

*Female White*

4. COLOR OR RACE

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

*Widow*

5A. IF MARRIED, WIDOWED, OR DIVORCED

*Widow of Dr. J. L. Northcraft*

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

*Sept-7-1848*

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, ... hrs. or ... min.

*82*

*2*

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)

*Housekeeping*

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

*Greene Co. Penn*

10. NAME OF FATHER

*John Waldman*

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

*Penn.*

12. MAIDEN NAME OF MOTHER

*May McComill*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

*Penn.*

14. INFORMANT

(Address)

*John Northcraft  
Labelle Mo*

15. FILED

*Sept 11, 1930*

*J. Northcraft*

REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept-9 1930*

17.

I HEREBY CERTIFY That I attended deceased from *Sept 7*, 19*30*, to *Sept 9*, 19*30* that I last saw him alive on *Sept 9*, 19*30*, and that death occurred, on the date stated above, at *3:30 P.M.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*apoplexy*  
*82 yr* / *Dr. J. L. Northcraft*

CONTRIBUTORY (SECONDARY)

*Hardening of arteries*

18. WHERE WAS DISEASE CONTRACTED

*at her sons*

DID AN OPERATION PRECEDE DEATH? *no* DATE OF

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *J. E. Carter, M.D.*

, 19 (Address) *Labelle 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

*Labelle Cemetery*

*9/11 1930*

20. UNDERTAKER

ADDRESS

*James T. Carter*

*Labelle 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.

*Wm. R. Carter*

