OCT 30 1930

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

Do not use this space.

30478

1. PLACE OF DEATH

County Macon — Registration District No. 534 — File No.

Township Ringer — Primary Registration District No. 5717 — Registered No. 23

City ..... (No. ..... St. ..... Ward)

2. FULL NAME Sarah Jenkins

(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): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Aug 30 - 1874

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
56	0	5	

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) (STATE OR COUNTRY): New Cambria Mo

PARENTS

10. NAME OF FATHER: William Burris

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

12. MAIDEN NAME OF MOTHER: Catherine Trail

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

14. INFORMANT: Joe Jenkins
(Address) New Cambria Mo

15. FILED 5-7-1930 G. T. Lunday, REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sept 5 1930

17. I HEREBY CERTIFY, That I attended deceased from April 22, 1930, to Sept 5, 1930 that I last saw her alive on Sept 5, 1930, and that death occurred, on the date stated above, at 5:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Dropsy

95B

..... (duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (SECONDARY): Heart Disease

..... (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? —

(Signed) Co. West, M.D

Sept 6, 1930 (Address) New Cambria 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: New Cambria Cemetery

DATE OF BURIAL: Sept 7 1930

20. UNDERTAKER: J. E. Gellelind

ADDRESS: New Cambria Mo

WRITE PLAINLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.