

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

Do not use this space.

527

1. PLACE OF DEATH

County Cedar
Township Box
City (No. _____) _____

Registration District No. 163
Primary Registration District No. 5728

File No. _____
Registered No. 4 Ward _____

2. FULL NAME

Sarah Overton Conner

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF S. W. Conner

7. DATE OF BIRTH (MONTH, DAY AND YEAR) May 12 1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
67 8 12

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). 250
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Wm Burris

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

12. MAIDEN NAME OF MOTHER Sarah Harvey

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

14. INFORMANT L. O. Conner (Address) Elmwood Spruce Mo R4

15. FILED 1-25-1931 J. W. Dawson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan-24 1931

17. I HEREBY CERTIFY, That I attended deceased from Oct 25 1930 to Jan 24 1931 that I last saw him alive on Oct 25 1930, and that death occurred, on the date stated above, at 10 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic interstitial nephritis

18. WHERE WAS DISEASE CONTRACTED 131 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 131 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) J. W. Dawson M. D.
(Address) Elmwood Spruce 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 Hazel Dell Cemetery DATE OF BURIAL 1/26 1931

20. UNDERTAKER Curran-Siders Elmwood Spruce Mo ADDRESS _____

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.

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