

1877-2

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

Do not use this space.

1877 ~~1877~~

1. PLACE OF DEATH

County Laclede
Township Union
City (No. _____) _____

Registration District No. 448
Primary Registration District No. 5608

File No. 16
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Sarah Beckner

(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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 27 1855

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
75 | 1 | 29 | 0

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) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lawrence Co Mo

10. NAME OF FATHER Joe Lerney

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

12. MAIDEN NAME OF MOTHER Emiline Haywood

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

14. INFORMANT Joe Lerney
(Address) Cowdoy Mo

15. FILED 77 1931 Jehnnet Clinton
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 26 1931

17. I HEREBY CERTIFY, That I attended deceased from 1-26-1931 to 1-26-1931 that I last saw her alive on 1-26-1931, and that death occurred, on the date stated above, at 4 P.M. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Chronic Valvular Heart Disease
72A

CONTRIBUTORY (SECONDARY) 72A
(duration) _____ yrs. _____ mos. _____ ds.

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

IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) C. P. ... M. D.
6-29-1931 (Address) Cowdoy 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 Gracelawn DATE OF BURIAL 1/28 1931

20. UNDERTAKER W.E. Halman ADDRESS Cowdoy

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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