

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

Do not use this space.

17952

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Raw Primary Registration District No. 100
 City R.P. Mo. (No. 2641-Forest) St. _____ Ward _____
 Registered No. 2503

2. FULL NAME

Sarah Elizabeth Thomas
 (a) Residence No. 4747 Terrace St. 1 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 <u>M</u>	4. COLOR OR RACE <u>Wh.</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>James Thomas</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Sept 14-1843</u>		
7. AGE	YEARS <u>87</u>	MONTHS <u>7</u>
	DAYS <u>23</u>	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>At Home</u> (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) <u>N.Y.</u>		
PARENTS	10. NAME OF FATHER <u>Franklyn Morrison</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>N.Y.</u>	
	12. MAIDEN NAME OF MOTHER <u>Helen Hunter</u>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>N.Y.</u>	

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May-7-1931
 17. I HEREBY CERTIFY, That I attended deceased from Apr. 1-31 May 7-1931 to May 7-1931, and that that I last saw her alive on May 7, 1931, and that death occurred, on the date stated above, at 11:47 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Diabetes Mellitus
59
16.2
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Smoking (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 59

IF NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Frank F. Berry, M. D.

May 7, 1931 (Address) 715 Chambers St

*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.

14. INFORMANT <u>Joseph Thomas</u> (Address) <u>3410 Washington</u>	19. PLACE OF BURIAL, CREMATION, OR REMOVAL <u>W.M. Washington</u>	DATE OF BURIAL <u>5-9-1931</u>
15. FILED <u>May 7, 1931</u> <u>M.M. Brown</u> REGISTRAR	20. UNDERTAKER <u>Mrs. C. L. Foster</u>	ADDRESS <u>R.P. Mo.</u>

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

Chambers. Ha-0181
3235 Bellmonte Li-2953