

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

Do not use this space.

**1. PLACE OF DEATH**

County Saline Registration District No. 796  
Township Marshall Primary Registration District No. 3038  
City Marshall Mo (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. 30232  
Registered No. 193-132

**2. FULL NAME**

Sarah Elizabeth Green  
(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 Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Fount Green  
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 8 1874  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
57 5 3  
8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work House wife  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Mo  
(STATE OR COUNTRY) \_\_\_\_\_  
10. NAME OF FATHER Meredith Johnson  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Virginia  
(STATE OR COUNTRY) \_\_\_\_\_  
12. MAIDEN NAME OF MOTHER unknown  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY) unknown

14. INFORMANT Fount Green  
(Address) Marshall Mo  
15. FILED 8-14 1931 Mrs John H McQuire  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 11 1931  
17. I HEREBY CERTIFY, That I attended deceased from Marshall Mo, 1931, to Aug 11 1931, that I last saw her alive on Aug 9 1931, and that death occurred, on the date stated above, at 10 4 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Pulmonary Tuberculosis  
2.9A  
(duration) \_\_\_\_\_ yrs. 5 mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) 23  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH Marshall Mo  
DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? no  
WHAT TEST CONFIRMED DIAGNOSIS Physical Exam  
(Signed) W. J. Madison M. D.  
, 19 \_\_\_\_\_ (Address) Marshall 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 Fairview Cem DATE OF BURIAL Aug 14 1931  
20. UNDERTAKER Ferguson Williams ADDRESS Marshall

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

SEP 28 1931

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.

