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

Do not use this space.

18493

1. PLACE OF DEATH
108 County Vernon — Registration District No. 875 — File No.
Township Washington — Primary Registration District No. 6162 — Registered No. 122
City Nevada (No. ..... St. ..... Ward)

2. FULL NAME Sarah Weathers
(a) Residence. No. St Hosp #3 St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 34 yrs. 9 mos. 15 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

JUN 03

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) D-14-1865

7. AGE: YEARS 67 — MONTHS 1 — DAYS — If LESS than 1 day, ... hrs. or ..... min.

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) Mo

PARENTS
10. NAME OF FATHER Milton Weathers
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown 31
(STATE OR COUNTRY) —
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) —
(STATE OR COUNTRY) —

14. INFORMANT Hosp record
(Address) Nevada Mo

15. FILED 6-7, 1932 E. R. King REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 26 1932

17. I HEREBY CERTIFY, That I attended deceased from Oct 15, 1928, to May 26, 1932 that I last saw her alive on May 26, 1932, and that death occurred, on the date stated above, at 6.45 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic myocarditis
67
92/80
(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Pellagra
(duration) ..... yrs. ..... mos. 14 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? Physical & symptoms
(Signed) F L Martin, M. D
, 19 (Address) Nevada 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: State Hospt Cemetary — DATE OF BURIAL: June 3 1932

20. UNDERTAKER: Fery Funeral Home — ADDRESS: Nevada 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.

V. S. N.