

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

Do not use this space.

36524

1. PLACE OF DEATH

73 County Monroe Registration District No. 608  
Township East Franklin Primary Registration District No. 5807  
City Sturgeon (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. 22

2. FULL NAME

Sarah E. Trunary  
(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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1857 Aug 15

7. AGE YEARS MONTHS DAYS IT LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
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8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Widowed  
(b) General nature of industry, business, or establishment in which employed (or employer) H. K. and kind  
(c) Name of employer with his children

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Indiana 2

10. NAME OF FATHER Daniel Sours

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT W. D. Trunary  
(Address) St. Louis City Mo.

15. FILED \_\_\_\_\_ 19 \_\_\_\_\_ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 20 1932

17. I HEREBY CERTIFY, That I attended deceased from Oct 30 1932 to Nov 20 1932 that I last saw her alive on Nov 16 1932 and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Broncho Pneumonia

CONTRIBUTORY (SECONDARY) 10 1/2 (duration) yrs. mos. ds.

19. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH (1)

DID AN OPERATION PRECEDE DEATH? DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Dr. Russell M. D.

, 19 (Address) Fairview 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 DATE OF BURIAL

St. Louis Cemetery 11/21 1932

20. UNDERTAKER ADDRESS

3506  
St. Louis Fairview Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Newton

Registration District No. 608

Township Franklin

Primary Registration District No. 5-807

City Newton (No.       )

File No.       

Registered No. 22

St.        Ward       

**2. FULL NAME**

Sarah E. Treanor

(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**

**MEDICAL CERTIFICATE OF DEATH**

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11/20 1932

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

22. I HEREBY CERTIFY, That I attended deceased from        to       , 19      

I last saw h..... alive on       , 19      . Death is said

to have occurred on the date stated above, at        m.

The principal cause of death and related causes of importance were as follows:

Date of onset

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, .....hrs. or .....min.

Other contributory causes of importance:

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year).....  
11. Total time (years) spent in this occupation.....

Name of operation..... Date of.....  
What test confirmed diagnosis?..... Was there an autopsy?.....  
23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide?..... Date of injury....., 19.....  
Where did injury occur?..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.  
Manner of injury.....  
Nature of injury.....

12. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)

MOTHER FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)

17. INFORMANT..... (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE..... DATE....., 19.....

19. UNDERTAKER..... (ADDRESS)

20. FILED Feb 11 19 32 L. N. Parnell Registrar

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed)....., M. D.

(Address).....

**SUPPLEMENTARY**

N. B.—Every item of information should be carefully supplied. AGE altered or stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is required. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED

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