

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

Do not use this space.

28351

**1. PLACE OF DEATH**

County..... Registration District No. 791  
 Township..... Primary Registration District No. 1003  
 City St. Louis (No. Barnard Tree Skin & Cancer Hosp Ward)

File No. ....  
 Registered No. 7502

**2. FULL NAME**

Sadie Crews  
 (a) Residence, No. Barnard Hospital, 21 Ward. Collinsville, Mo.  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married.</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF <u>Joseph Crews</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Dec 25-1874</u>				
7. AGE	YEARS <u>58</u>	MONTHS <u>8</u>	DAYS <u>5</u>	IF LESS than 1 day, .....hrs. or .....min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Housewife</u>			
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>own home</u>			
	10. Date deceased last worked at this occupation (month and year) <u>June 9 33</u> 11. Total time (years) spent in this occupation <u>40</u>			
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Texas</u>				
MOTHER FATHER	13. NAME <u>Douglas Elmore</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Not known</u>			
	15. MAIDEN NAME <u>Not known</u>			
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Not known</u>				
17. INFORMANT <u>Hannie Harrelson</u> (ADDRESS) <u>Collinsville, Mo.</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Collinsville, Mo.</u> DATE <u>Aug 30</u> 19 <u>33</u>				
19. UNDERTAKER <u>Geo. M. Schaeppel</u> (ADDRESS) <u>Collinsville, Mo.</u>				
20. FILED: <u>31</u> <u>33</u> 19 <u>33</u> <u>J. Brebeck</u> Registrar.				

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 30 1933

22. I HEREBY CERTIFY, That I attended deceased from 8/21 1933, to 8/30 1933  
 I last saw her alive on 8/30 1933. Death is said to have occurred on the date stated above, at 8:21 A.M.  
 The principal cause of death and related causes of importance were as follows:  
Uremia  
275 B  
135 B  
1/8  
 Date of onset 8/12/33

Other contributory causes of importance:  
Failure of service

Name of operation Radical amputation Date of 8/22/33  
 What test confirmed diagnosis? N.P.N. Was there an autopsy? No

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.....

24. Was disease or injury in any way related to occupation of deceased? No  
 If so, specify.....  
 (Signed) J. T. Munnig, M. D.  
 (Address) 3427 Washington Ave.

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.

SEP 26 1933

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