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

Do not use this space.

11815

MAY 23 1934

1. PLACE OF DEATH
County: Atchison
Township: Templeton
City: ..... (No. ....., ... St. ..... Ward)

Registration District No. 19
Primary Registration District No. 5023

File No.
Registered No.

2. FULL NAME: Sadie File

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-12-1864

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	2	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housekeeper
(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): Atchison Co. Mo

PARENTS
10. NAME OF FATHER: Wm. File
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Germany
12. MAIDEN NAME OF MOTHER: Elizabeth Whitney
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Germany

14. INFORMANT: Eddie Kimberlain
(Address): Phelps City, Mo

15. FILED 4-18, 1934 Mary G Chamberlain REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-18 1934

17. I HEREBY CERTIFY, That I attended deceased from April 16 1934, to April 18 1934, that I last saw her alive on April 18 1934, and that death occurred, on the date stated above, at 7.30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
(duration) ..... yrs. ..... mos. 3 ds.
CONTRIBUTORY (SECONDARY) Nephritis
(duration) ..... yrs. ..... mos. ..... 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?
(Signed) C. A. Lewis, M. D.
4-18, 1934 (Address) Rock Port 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
Greenhill Cem.	4-20 1934
20. UNDERTAKER	**ADDRESS**
Gratz Bartholomew	Rock Port, Mo

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