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.

WHITE PAPER, WITH CHARCOAL INK—THIS IS A PERMANENT RECORD

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

MAR 20 1935

Do not use this space.

B-77 5381

1. PLACE OF DEATH

County Jackson — Registration District No. 399 — File No.

Township Kansas — Primary Registration District No. 1002 — Registered No.

City K. C. Mo. (No. K. C. General Hospital St. Ward)

2. FULL NAME Sallie Zerbaugh

(a) Residence, No. 121 No. Topping 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*): Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb-22-1847

7. AGE: Years 87 — Months 11 — Days 19 — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housework
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

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

FATHER

13. NAME No Record
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) " "

MOTHER

15. MAIDEN NAME No Record
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) " "

17. INFORMANT (ADDRESS) Eugene Zerbaugh 121 No. Topping ave

18. BURIAL, CREMATION, OR REMOVAL
PLACE Mt. Moriah DATE 3/12/35

19. UNDERTAKER (ADDRESS) Mrs. E. L. Foster 918 Brooklyn avenue

20. FILED 3/12, 1935 M. M. Crowe, Asst. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb-11-35

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

Other contributory causes of importance:

Name of operation ..... Date .....
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 .....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, at home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

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

Dynty Coroner
Acute Pancreatitis
Appendicitis
Acute peritonitis
No
Autopsy
No
Accident
Fall
Fall in bath tub injury
Hemorrhage
Death