

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

Do not use this space.

110054-d

APR 24 1935

**1. PLACE OF DEATH**

County Clark  
 Township Big Creek  
 City (No. ....) .....

Registration District No. 920  
 Primary Registration District No. 5838

File No. ....  
 Registered No. 1  
 St. .... Ward

**2. FULL NAME**

Sarah Ann Leva Sullivan

(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 60 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 W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 10 - 1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
74 1 3

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work. Involved  
 (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) Ark

10. NAME OF FATHER Marion Miller

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT Dasia Jones  
 (Address) Lutie mo

15. FILED Mar 16, 1935 Mary H. Johnson  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 15 1935

17. I HEREBY CERTIFY, That I attended deceased from no medical aid 19... that I last saw h... alive on ... 19... and that death occurred, on the date stated above, at 7 P m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Kidney trouble

CONTRIBUTORY (SECONDARY) Rheumatism (duration) 2 yrs. mos. ds.

(duration) 30 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS no medical aid

(Signed) Dasia Jones M. D.

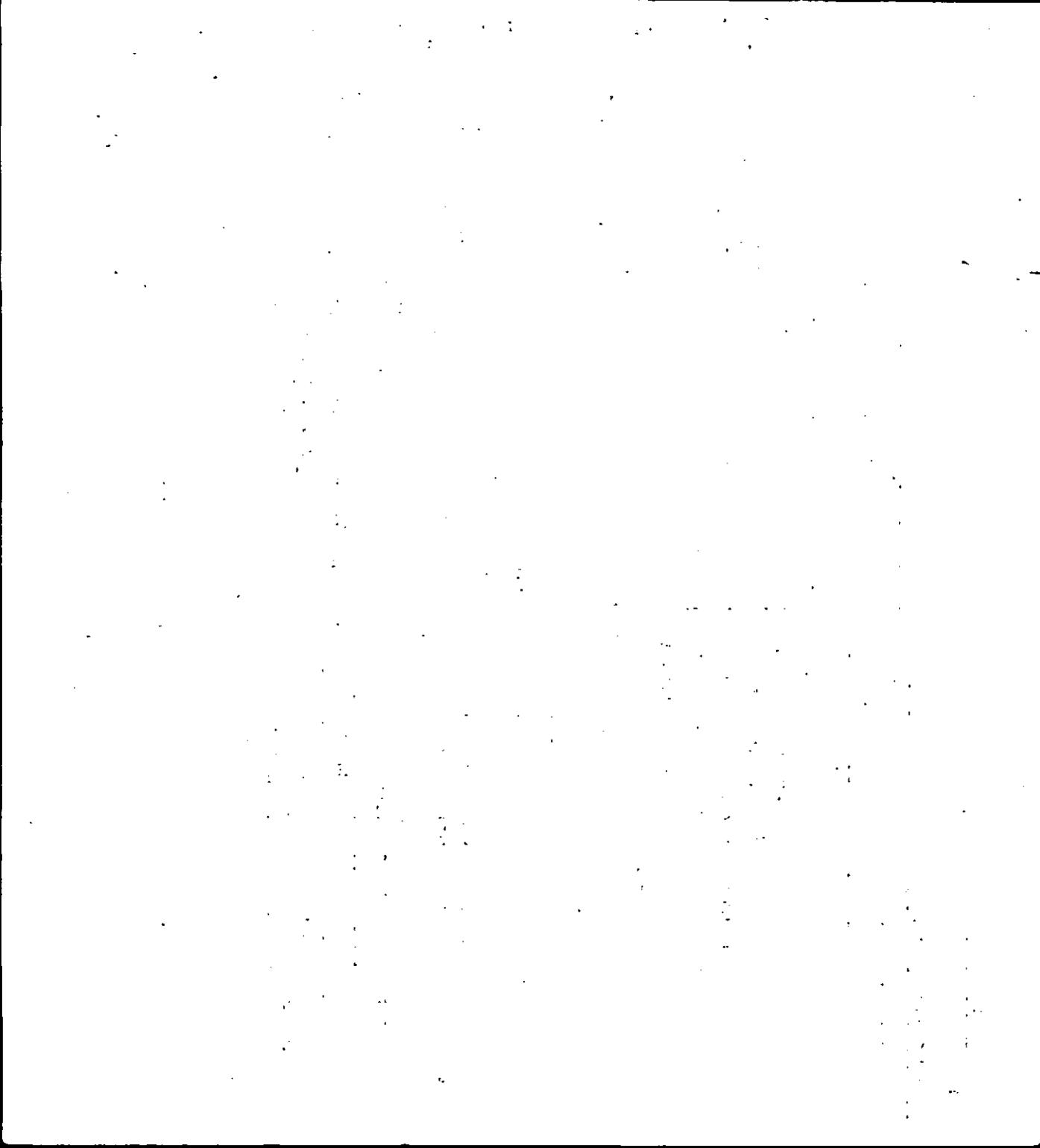
3/16 1935 (Address) Lutie mo

\*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 Lutie cemetery DATE OF BURIAL Mar 16 1935

20. UNDERTAKER B. N. Reich ADDRESS Lutie mo

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.



**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

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**1. PLACE OF DEATH**

County Ozark  
Township .....  
City ..... (No. .... St. .... Ward)

Registration District No. 920  
Primary Registration District No. 5858

File No. ....  
Registered No. ....

**2. FULL NAME**

(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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) W

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 15, 1935

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

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

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

I last saw him alive on ....., 19..... Death is said to have occurred on the date stated above, at.....m.

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

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

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

Kidney Trouble  
Date of onset

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

Over flow of the bladder made too much water  
Other contributory causes of importance: poor water

13. NAME

Name of operation ..... Date of .....  
What test confirmed diagnosis? ..... Was there an autopsy? .....

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

23. If death was due to external cause (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)

15. MAIDEN NAME

Specify whether injury occurred in industry, in home, or in public place.

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

Manner of injury .....  
Nature of injury .....

17. INFORMANT (ADDRESS)

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

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19.....

19. UNDERTAKER (ADDRESS)

(Signed) Mary F. Johnson L.R. M.D.  
(Address) Julian

20. Mar 16, 1935 Mary F. Johnson Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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