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

Do not use this space.

OCT 28 1935

File No. 30399

1. PLACE OF DEATH
County Pulaski Registration District No. 713
Township Cullen Primary Registration District No. 3942
Registered No.
City ..... (No. ..... St. ..... Ward)

2. FULL NAME SARAH CARVER

(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	Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2/12/53

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	82	7	13	

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. At home
10. Date deceased last worked at this occupation (month and year) 1925
11. Total time (years) spent in this occupation Life

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

FATHER
13. NAME William Carver
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

MOTHER
15. MAIDEN NAME Winnie Cole
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT (ADDRESS) J. W. Carver Waynesville

18. BURIAL, CREMATION, OR REMOVAL
PLACE Antioch Cem DATE 9/27 1935

19. UNDERTAKER (ADDRESS) J. L. Hoover & Sons Waynesville

20. FILED 9/26 1935 C. A. Talbot Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9/26 1935

22. I HEREBY CERTIFY, That I attended deceased from 9/18 1935 to 9/25 1935
I last saw her alive on 9/25 1935. Death is said to have occurred on the date stated above, at 1 P. m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Stroke	
Fractured femur	

Other contributory causes of importance: 1860

Name of operation None Date of
What test confirmed diagnosis? Physical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Accident Date of injury 9/18 1935
Where did injury occur? Home Cabin Camp
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Home
Manner of injury Fell
Nature of injury Fractured femur

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) C. A. Talbot M. D.
(Address) Waynesville 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.