

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
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

DEC 18 1935

35863

1. PLACE OF DEATH

County Lainson
Township Lincoln
City (No.)

Registration District No. 346
Primary Registration District No. 5484

File No.
Registered No. 8
St. Ward

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

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 (OR) WIFE OF <u>Husband</u> <u>Leo Allen</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Mar-16-1847</u>				
7. AGE	YEARS <u>88</u>	MONTHS <u>8</u>	DAYS <u>14</u>	IF LESS than 1 day,hrs. ormin.
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> </u>			
	10. Date deceased last worked at this occupation (month and year) <u> </u>		11. Total time (years) spent in this occupation <u> </u>	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>New York</u>				
FATHER	13. NAME <u>Edson Sabine</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u> </u>			
MOTHER	15. MAIDEN NAME <u> </u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u> </u>			
17. INFORMANT <u>Leo Allen</u> (ADDRESS) <u> </u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Wegman Chapel</u> DATE <u>12/1</u> 19 <u>35</u>				
19. UNDERTAKER <u>Frank W. Kraus</u> (ADDRESS) <u> </u>				
20. FILED <u>Dec 9 1935</u> <u>Chas. Adair</u> Registrar.				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov-30 1935

22. I HEREBY CERTIFY, That I attended deceased from Nov-28, 1935, to Nov-30, 1935.

I last saw her alive on Nov-28, 1935. Death is said to have occurred on the date stated above, at 10:45 a.m.

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

Pneumonia Lobar Date of onset Nov 28-30

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Physical findings 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) , M. D.

(Address)

