

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

Do not use this space.

X

21132

1. PLACE OF DEATH  
 County Woods  
 Township Carroll  
 City (No. \_\_\_\_\_)

Registration District No. 5-78  
 Primary Registration District No. 5079 A

File No. \_\_\_\_\_  
 Registered No. \_\_\_\_\_  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Sarah D. Vance  
 (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 female  
 4. COLOR OR RACE white  
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 15 1937

6A. IF MARRIED, WIDOWED, OR DIVORCED  
 (OR) WIFE OF Dave Vance

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-16-1898  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hr. or \_\_\_\_\_ min.  
39 3 1

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Metral Resurgitation  
 Bronchitis

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work house wife  
 (b) General nature of industry, business, or establishment in which employed (or employer) her home  
 (c) Name of employer \_\_\_\_\_

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Georgia

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_

10. NAME OF FATHER Hentt Harmon

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Georgia

18. WAS THERE AN AUTOPSY? no

12. MAIDEN NAME OF MOTHER Eliza Jacobs

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_ (Signed) \_\_\_\_\_, M. D.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Georgia

, 19 \_\_\_\_\_ (Address)

14. INFORMANT \_\_\_\_\_ (Address) \_\_\_\_\_

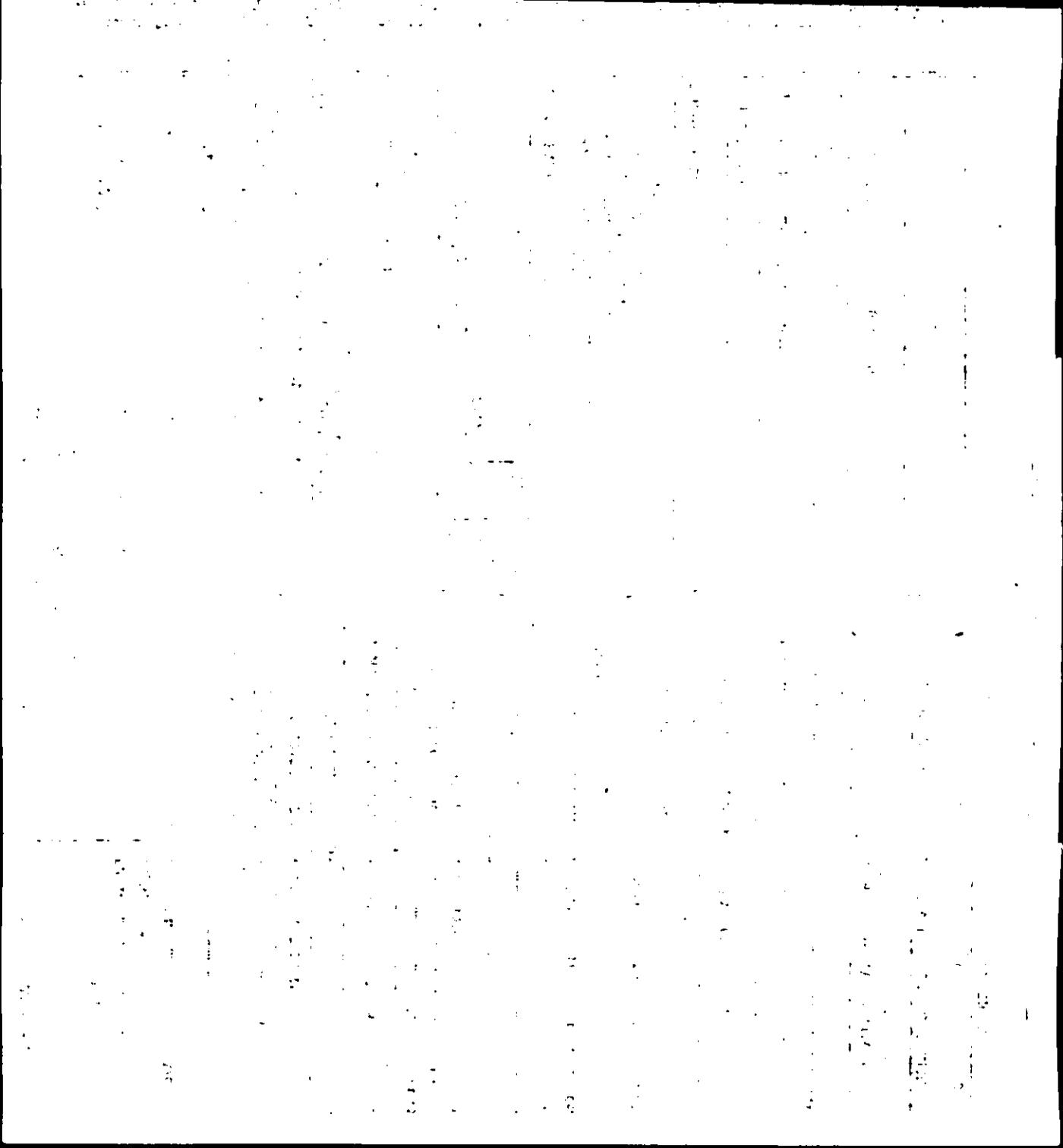
\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

15. FILED \_\_\_\_\_, 19 \_\_\_\_\_ REGISTRAR \_\_\_\_\_

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Ellington, Mo. DATE OF BURIAL \_\_\_\_\_ 19 \_\_\_\_\_

20. UNDERTAKER Croy ADDRESS \_\_\_\_\_

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.



# CROY FUNERAL SERVICE

FUNERAL HOMES  
Van Buren, Mo.  
Greenville, Mo.

REPRESENTATIVE  
St. Louis, Mo.

BRANCH OFFICES  
Ellington, Mo.  
Eminence, Mo.

van Buren, Mo.  
May 20, 1937

Dr. Henson  
Bunker, Mo.

Dr. Henson:

When making out this Certificate of Death, you evidently overlooked signing the medical certificate. Would you please sign this and drop it in the Post Office. Find enclosed a stamped, addressed envelope.

Thank you,

*W. C. Croy*  
W. C. Croy

Bunker, Mo. May 23, 1937

Mr. Croy

van Buren, Mo.

Dear sir: I did not attend Mrs. Vance  
in her last illness so of course I could  
not sign her death certificate

L. L. Henson M. D.

S-21132