

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

15916

DO NOT use this space.

1. PLACE OF DEATH
 County Henry, Registration District No. 347
 Township Leesville, Primary Registration District No. 5501A
 City Leesville, (No.) St. Ward
 Registered No. 39

2. FULL NAME Mrs, Sarrah Beck,
 (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 F. 4. COLOR OR RACE White, 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married,

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 5 1853

| | | | | |
|-----------|-------|----------|-----------|----------------------------------|
| 7. AGE | YEARS | MONTHS | DAY | IF LESS than 1 day, hrs. or min. |
| <u>76</u> | | <u>9</u> | <u>26</u> | |

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Home keeper,
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Norvo,
 (STATE OR COUNTRY) Ill,

10. NAME OF FATHER J.E.Folley,

11. BIRTHPLACE OF FATHER (CITY OR TOWN) dont know,
 (STATE OR COUNTRY) Ireland

12. MAIDEN NAME OF MOTHER dont know,

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) dont know,
 (STATE OR COUNTRY) Ireland,

14. INFORMANT John W. Beck,
 (Address) Clinton Mo. R.F.D.

15. FILED 6/4 30 1930 Dr. E. C. Peelor
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 31 1930

17. I HEREBY CERTIFY, That I attended deceased from May 27, 1930, to May 31, 1930 that I last saw her alive on May 27, 1930, and that death occurred, on the date stated above, at 5 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Influenza
11B
 (duration) yrs. mos. 5 ds.

CONTRIBUTORY (SECONDARY) 11B
 (duration) yrs. mos. ds.

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

8 DID AN OPERATION PRECEDE DEATH..... DATE OF

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) A. Swacker, M. D.
6-3, 1930 (Address) Clinton 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 Lebo Lane DATE OF BURIAL June 2nd 1930

20. UNDERTAKER L. B. Calbert Lincoln Mo. ADDRESS

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.

