

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

Do not use this space.

926

1. PLACE OF DEATH

County Henry
Township Leesville
City Leesville (No.)

Registration District No. 347
Primary Registration District No. 5501A

File No.
Registered No. 5
St. Ward)

2. FULL NAME

Sabrina Heckert

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 20 1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
72 1 7

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

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

13. NAME Johnnie Fowler

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

15. MAIDEN NAME Sarah Maidens

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

17. INFORMANT (ADDRESS) Harry Heckert Clinton RR

18. BURIAL, CREMATION, OR REMOVAL PLACE Good Hope DATE 1-28 1934

19. UNDERTAKER (ADDRESS) Spore Bros

20. FILED 1-29 1934 J R Hampton Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 28 1934

22. I HEREBY CERTIFY That I attended deceased from Jan 1 1933 to Jan 27 1934

I last saw her alive on Jan 26 1934. Death is said to have occurred on the date stated above, at 78 1/2 min.

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

General debility
& heart aortic

Other contributory causes of importance: None

Name of operation None Date of None

What test confirmed diagnosis? None Was there an autopsy? None

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? no Date of injury None, 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 no

Nature of injury none

24. Was disease or injury in any way related to occupation of deceased?

If so, specify None

(Signed) Samuel Poague, M. D.

(Address) Clinton 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.

FEB 27 1934

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

