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

Do not use this space. 34862

94

1. PLACE OF DEATH

County St Francois Registration District No. 994 File No. 87

Township St Francois Primary Registration District No. 6018B Registered No.

City Flat River (No. St. Ward)

2. FULL NAME Sarah McDaniel

(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(Usual place of abode)

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)
F	white	widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 8-1848

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ......min.
	81	4	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Tenn

PARENTS

10. NAME OF FATHER Sandford Burgess

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Not Known

12. MAIDEN NAME OF MOTHER Nancy Hart

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Not Known

14. INFORMANT Mr. Joseph McDaniel
(Address) St Louis Mo.

15. Filed 10/29/1929 W J Bryan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-15 1929

17. I HEREBY CERTIFY, That I attended deceased from 10-12, 1929, to 10-15, 1929 that I last saw h... alive on 10-15, 1929, and that death occurred, on the date stated above, at 2:10 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hemostatic pneumonia
107 A

(duration) ...... yrs. ...... mos. 7 ds.

CONTRIBUTORY (SECONDARY) Emphysema of lungs

(duration) 5 yrs. ...... mos. ...... ds.

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

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

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) N. M. Fuller, M. D

10-16, 1929 (Address) Desloge 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	DATE OF BURIAL
Parkview Cemetery	10-17 1929
20. UNDERTAKER	ADDRESS
Raymond Caldwell	Flat River

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.

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REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St Francois Registration District No. 774 File No. 87

Township " " " Primary Registration District No. 6018 B Registered No. ....

City " (No. ...., ... St. .... Ward)

2. FULL NAME Sarah McDaniels

(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)
F	W	W

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

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

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

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

9. BIRTHPLACE (CITY OR TOWN) ....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT ....
(Address)

15. FILED Nov 29 1929 W J Bryan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 15 1929

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.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia
Hemostatic
Bronchial

.... (duration) ....yrs. ....mos. ....ds.

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

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

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

WAS THERE AN AUTOPSY? ....

WHAT TEST CONFIRMED DIAGNOSIS? ....

(Signed) ...., M. D.

, 19 (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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
	19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

100 W

1929
34862