

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

Do not use this space.

35509

1. PLACE OF DEATH

County St. Francois
Township St. Francois

Registration District No. 773
Primary Registration District No. 6018A

File No. _____
Registered No. 136
St. _____ Ward _____

Near City Farmington, Mo. (No. _____)

2. FULL NAME Carrie Sears

(a) Residence No. Desloge, Mo. 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 HUSBAND OF (OR) WIFE OF <u>Unknown</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Unknown</u>		
7. AGE	YEARS	MONTHS
	<u>47</u>	<u>?</u>
		<u>?</u>
	If LESS than 1 day, _____ hrs. or _____ min.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(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) Missouri

PARENTS	10. NAME OF FATHER <u>Unknown</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Unknown</u>
	12. MAIDEN NAME OF MOTHER <u>Unknown</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Missouri</u>

14. INFORMANT Hospital Records
(Address) Farmington, Mo.

15. FILED 10-20-31 J. Robinson
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 19 1931

17. I HEREBY CERTIFY, That I attended deceased from April 1 1928 to Oct 19 1931
that I last saw her alive on Oct 18 1931, and that death occurred, on the date stated above, at 8:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocardia
131
93c

(duration) 2 yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Chronic Interstitial Nephritis
(duration) yrs. mos. ds. 6

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

0 DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) C. F. Hoctor M.D.

10-20-1931 (Address) Farmington, 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 St. Francois Mo DATE OF BURIAL Oct-20-31

20. UNDERTAKER C. L. Boyer ADDRESS Desloge Mo

WRITE PLAINLY, WITH UNFADING INK--THIS IS PERMANENT RECORD

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.

NOV 20 1931

