WRITE PLAINLY, WITH UNFADING INK—THIS IS A 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.

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

PLACE OF DEATH

County Pettis

Township or Village or City Sedalia (No. 1006 West 7" St.; Ward)

Registration District No. 668 — File No. 33754

Primary Registration District No. 3032 — Registered No. 250

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME William M. Alspaugh

PERSONAL AND STATISTICAL PARTICULARS

SEX: male

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): married

DATE OF BIRTH: Sept 26, 1850 (Month) (Day) (Year)

AGE: 63 yrs. mos. ds. — If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE (City or town, State or foreign country): Ohio

PARENTS

NAME OF FATHER: Ruben Alspaugh

BIRTHPLACE OF FATHER (City or town, State or foreign country): Penn.

MAIDEN NAME OF MOTHER: Effie Pence

BIRTHPLACE OF MOTHER (City or town, State or foreign country): U. S. A.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Jennie Boyd

(ADDRESS) Malin Mo.

Filed Oct 27, 1913. F. B. Long, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct. 25, 1913 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 17, 1913, to Oct 25, 1913, that I last saw him alive on Oct. 25, 1913, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

93C 01

(Duration) yrs. mos. 21 ds.

Contributory (SECONDARY) Fatty Heart

(Duration) yrs. mos. ds.

(Signed) A. R. Barnum M. D.

10/27 1913 (Address) Sedalia

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Crown Hill — DATE OF BURIAL: Oct 28, 1913

UNDERTAKER: McLaughlin — ADDRESS: Sedalia

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

PLACE OF DEATH

County_____

Township _____ Registration District No._____ File No._____
or
Village_____ Primary Registration District No._____ Registered No._____
or
City _____(NO._____ _____St.;_____Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME_____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____, *1*_____
(Month) (Day) (Year)

AGE

_____yrs._____mos._____ds.

If LESS than 1 day,____hrs. or____min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

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

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER (City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)_____

(ADDRESS)_____

Filed _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____, *191*____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to_____, 191____, that I last saw h____alive on_____, 191____, and that death occurred, on the date stated above, at_____m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____(Duration)_____yrs._____mos._____ds.

Contributory_____
(SECONDARY)

_____(Duration)_____yrs._____mos._____ds.

(Signed)_____ M. D.

_____, 191____ (Address)_____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death____yrs.____mos.____ds. In the State____yrs.____mos.____ds.

Where was disease contracted if not at place of death? _____

Former or usual residence_____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191____
UNDERTAKER	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.

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