

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. 209 S. 2nd - St.; _____ Ward)Registration District No. 668File No. 37041Primary Registration District No. 3032Registered No. 258

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

FULL NAME James H. Wiley

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>M.</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>
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DATE OF BIRTH Sept - 15 - 1864
(Month) (Day) (Year)

AGE 64 yrs. 21 mos. 21 ds. IF LESS than
1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work 6-11

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

BIRTHPLACE
(City or town, State or foreign country) Ill.

PARENTS

NAME OF FATHER <u>Joseph Wiley</u>
BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ill.</u>
MAIDEN NAME OF MOTHER <u>Harvey McDonald</u>
BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>S. Carolina</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. H. Wiley(ADDRESS) 209 S. 2ndFiled Nov 7, 1913, A. B. Long

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov - 6, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 1, 1913, to Sept 1, 1913,
that I last saw him alive on Sept 1, 1913,
and that death occurred, on the date stated above, at 5 P m.
The CAUSE OF DEATH* was as follows:

Locomotor Ataxia

80 (Duration) 10 yrs. 10 mos. 10 ds.

Contributory (SECONDARY)

(Signed) M. P. Barman M. D.
11/7, 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 Baldwin Hill

DATE OF BURIAL 11-7-, 1913UNDERTAKER SedaliaADDRESS Sedalia

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

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

PLACE OF DEATH

County _____

Township _____
or _____

Village _____
or _____

City _____ (NO. _____)

Registration District No. _____

Primary Registration District No. _____

File No. _____

Registered 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 _____ (If file the word)

DATE OF BIRTH _____ (Month) _____, 191____ (Day) _____, 191____ (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) _____

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

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him 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) _____

(Signed) _____ (Duration) _____ yrs. _____ mos. _____ ds.

_____ 191____ (Address) _____ M. D.

*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 _____