

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 Hall
Township Proper
or
Village i
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 223 File No. 3 **40395**
Primary Registration District No. 5960 Registered No. 76

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

FULL NAME J. M. Sunderland

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED Married
WIDOWED OR DIVORCED
(Write the word)

DATE OF BIRTH Feb 18 1854
(Month) (Day) (Year)

AGE 59 yrs. mos. ds. IF LESS than 1 day, hrs. or min.?

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

BIRTHPLACE
(City or town, State or foreign country) Indiana

PARENTS
NAME OF FATHER X unknown
BIRTHPLACE OF FATHER (City or town, State or foreign country) Maryland
MAIDEN NAME OF MOTHER X unknown
BIRTHPLACE OF MOTHER (City or town, State or foreign country) X unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) N. W. Alonzo
(ADDRESS) New London

Filed 12-8 1913 W. P. Binn
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 7, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 21, 1913, to Dec 5, 1913, that I last saw h. alive on Dec 5, 1913, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

Syphilitic Pneumonia
109A
(Duration) yrs. mos. 16 ds.

Contributor (SECONDARY) (Duration) yrs. mos. ds.
(Signed) W. P. Binn M. D.
Dec 8 1913 (Address) Center Mo

*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 Berkley Cem

DATE OF BURIAL Dec 8, 1913

UNDERTAKER J. W. Binn ADDRESS Center Mo

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

County _____
 Township _____
 City _____
 State _____
 (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 write the word)
DATE OF BIRTH	(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) _____

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 _____ (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) _____ (Address) _____, 191____ 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. 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

UNDERTAKER

ADDRESS