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.

PLACE OF DEATH Dr Long

County Pettis

Township or Village or City Sedalia (NO. 16th & Prospect St.; Ward)

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

Registration District No. 668 File No. 9534

Primary Registration District No. 3032 Registered No. 66

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

FULL NAME Samuel Paradis

PERSONAL AND STATISTICAL PARTICULARS

SEX: male

COLOR OR RACE: White

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

DATE OF BIRTH: (Month) (Day) 1839 (Year)

AGE: 75 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

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

BIRTHPLACE (City or town, State or foreign country): Montreal Canada

PARENTS
NAME OF FATHER: Unknown
BIRTHPLACE OF FATHER (City or town, State or foreign country):
MAIDEN NAME OF MOTHER: Unknown
BIRTHPLACE OF MOTHER (City or town, State or foreign country):

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Paradis

(ADDRESS) Sedalia Mo.

Filed Mch. 5. 1914. R. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

DATE OF DEATH: Mch. (Month) 5 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Feb. 23, 1914, to Mch. 5, 1914, that I last saw him alive on Mch. 4, 1914, and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Liver.
4 hrs.
131
1064
(Duration) Years Months

Contributory (SECONDARY) Chronic Interstitial Nephritis
Cause Chronic Bronchitis
(Duration) yrs. mos. ds.

(Signed) R. B. Long M. D.

Mch. 5. 1914. (Address) Sedalia 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: Catholic Cemetary

DATE OF BURIAL: Mar 6. 1914

UNDERTAKER: McLaughlin Bros.

ADDRESS: Sedalia Mo

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 _____

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.

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

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