

PLACE OF DEATH

County Shelby
Township Blackhawk
or
Village
or
City Shelbyville (NO. _____ St.; _____ Ward)

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

Registration District No. 831 File No. 11266
Primary Registration District No. 4504 Registered No. 7

FULL NAME Sarah E. Ammentrout

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

PERSONAL AND STATISTICAL PARTICULARS

SEX female COLOR OR RACE white SINGLE married
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH October 28, 1841
(Month) (Day) (Year)

AGE 72 yrs. 4 mos. 4 ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

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

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

PARENTS
NAME OF FATHER Isaac Smith
BIRTHPLACE OF FATHER (City or town, State or foreign country) Pennsylvania
MAIDEN NAME OF MOTHER Lama Smith
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. M. Ammentrout
(ADDRESS) Shelbyville Mo

Filed 3-3- 1914 W. H. Carson

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 2, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 26, 1914, to March 2, 1914, that I last saw her alive on March 2, 1914, and that death occurred, on the date stated above, at 8:30 m.

The CAUSE OF DEATH was as follows:

Broncho -
- Pneumonia
107 B

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. H. Keiser M. D.
March 3, 1914 (Address) Shelbyville

*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 Shelbyville Mo DATE OF BURIAL March 5, 1914

UNDERTAKER J. H. Thompson ADDRESS Shelbyville Mo

PLACE OF DEATH

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

County _____

Township _____

or

Village _____

or

City _____ (NO _____)

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

_____ St. _____ Ward _____

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED OR DIVORCED (If not the word)
DATE OF BIRTH _____, 191____, (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 for _____

_____, 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) _____

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

UNDERTAKER

ADDRESS