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. ____ St.; ____ Ward)

Registration District No. 668 — File No. 20165

Primary Registration District No. 3132 — Registered No. 133

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

**FULL NAME** Sarah Truel

**PERSONAL AND STATISTICAL PARTICULARS**

| SEX | COLOR OR RACE | SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) |
|---|---|---|
| Female | White | Married |

DATE OF BIRTH: June (Month) 6 (Day), 1863 (Year)

AGE: 50 yrs. 11 mos. 25 ds. — If LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE (City or town, State or foreign country): Clayburn Tenn

PARENTS
NAME OF FATHER: unk Thompson
BIRTHPLACE OF FATHER (City or town, State or foreign country): Tenn.
MAIDEN NAME OF MOTHER: dont know
BIRTHPLACE OF MOTHER (City or town, State or foreign country): " " U.S.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W H Truel

(ADDRESS) Sedalia Mo.

Filed June 1, 1914. H. B. Long REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH: May (Month) 31 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Mch 24, 1914, to May 31, 1914, that I last saw h alive on May 30, 1914, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Dry Gangrene of leg

9248 / 9488 — 147

(Duration) ____ yrs. 3 mos. — ds.

Contributory (SECONDARY) Valvular heart trouble

(Duration) ____ yrs. — mos. — ds.

(Signed) Ed Moore M. D.

June 1, 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: Crown Hill — DATE OF BURIAL: June 1, 1914

UNDERTAKER: McLaughlin Bros — ADDRESS: Sedalia Mo

**PLACE OF DEATH**

# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE 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 import