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

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. M.K. & T Hospital St.: ____ Ward)

Registration District No. 668 — File No. 29976

Primary Registration District No. 3032 — Registered No. 224

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

FULL NAME John Wesley Rimer

PERSONAL AND STATISTICAL PARTICULARS

SEX: M — COLOR OR RACE: W — SINGLE ~~MARRIED~~ ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word)

DATE OF BIRTH: — (Month) — (Day) 846 (Year)

AGE: 68 yrs. — mos. — ds. — If LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE (City or town, State or foreign country): Sales Vill Ohio

PARENTS
NAME OF FATHER: John W Rimer
BIRTHPLACE OF FATHER (City or town, State or foreign country): Ohio
MAIDEN NAME OF MOTHER: Mary Conover
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J Rimer

(ADDRESS) Sedalia Mo.

Filed Sept 14, 1914 F. B. Pong REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: June (Month) 9 (Day) 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from June 2, 1913, to Sept 9, 1914, that I last saw him alive on June 9, 1914, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

93C

79

(Duration) 3 yrs. ____ mos. ____ ds.

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

8 (Signed) M R Sly M. D.

9/9, 1914 (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: Crown Hill — DATE OF BURIAL: Sep. 14, 1914

UNDERTAKER: McLaughlin Bros — ADDRESS: 515 Ohio St

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 _____

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

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.

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*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) _____

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