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 Mo (NO. ____ St.: ____ Ward)

Registration District No. 668 — File No. 39749

Primary Registration District No. 3032 — Registered No. 315

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

FULL NAME Sara Ann Williams

PERSONAL AND STATISTICAL PARTICULARS

SEX: F — COLOR OR RACE: W — SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: June 10, 1857 (Month) (Day) (Year)

AGE: 56 yrs. — mos. — ds. — If LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE (City or town, State or foreign country): Mo

PARENTS
- NAME OF FATHER: James Cox
- BIRTHPLACE OF FATHER (City or town, State or foreign country): Mo
- MAIDEN NAME OF MOTHER: Louie Morrison
- BIRTHPLACE OF MOTHER (City or town, State or foreign country): Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. N. Williams

(ADDRESS) 1220 E 4th

Filed Dec 30 1914 A. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Dec (Month) 30 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 25 1914 to Dec 30, 1914, that I last saw her alive on Dec 28, 1914, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus

(Duration) 2 yrs. ____ mos. ____ ds.

Contributory (SECONDARY) ____

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

(Signed) Frank R Morley M. D.

Dec 31 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: Versailles Mo — DATE OF BURIAL: 12/31 1914

UNDERTAKER: Maly & Landis — ADDRESS: Sedalia Mo

Revised United States Standard Certificate

MISSOURI STATE BOARD OF HEALT
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 hospital or institut give its NAME ins 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) (Yea

I HEREBY CERTIFY, that I attended deceased fr ....., 191..., to ....., 191..

that I last saw h ..... alive on ....., 191..

and that death occurred, on the date stated above, at .....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. .....

Contributory .....
(SECONDARY)

..... (Duration) ..... yrs. ..... mos. .....

(Signed) ..... M.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, st (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. .....

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