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| PLACE OF DEATH                                                                                   |                                                                                      | MISSOURI STATE BOARD OF HEALTH<br>BUREAU OF VITAL STATISTICS<br>CERTIFICATE OF DEATH                                                                |                                                                                              |
|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| County                                                                                           | <u>Pettis</u>                                                                        | Registration District No.                                                                                                                           | <u>668</u> File No. <u>25508</u>                                                             |
| Township                                                                                         |                                                                                      | Primary Registration District No.                                                                                                                   | <u>3032</u> Registered No. <u>216</u>                                                        |
| Village                                                                                          |                                                                                      |                                                                                                                                                     |                                                                                              |
| City                                                                                             | <u>Sedalia</u> (No. <u>404 N. Prospect</u> St.: _____ Ward _____)                    |                                                                                                                                                     | (If death occurred in a hospital or institution, give its NAME instead of street and number) |
| FULL NAME <u>Abby Lytle McLaughlin Wakefield</u>                                                 |                                                                                      |                                                                                                                                                     |                                                                                              |
| PERSONAL AND STATISTICAL PARTICULARS                                                             |                                                                                      | MEDICAL CERTIFICATE OF DEATH                                                                                                                        |                                                                                              |
| SEX                                                                                              | COLOR OR RACE                                                                        | DATE OF DEATH                                                                                                                                       |                                                                                              |
| <u>F</u>                                                                                         | <u>W</u>                                                                             | <u>Aug. 19, 1915</u><br>(Month) (Day) (Year)                                                                                                        |                                                                                              |
| SINGLE MARRIED WIDOWED OR DIVORCED (If write the word)                                           |                                                                                      | I HEREBY CERTIFY, that I attended deceased from                                                                                                     |                                                                                              |
| <u>Married</u>                                                                                   |                                                                                      | <u>Aug 10, 1915, to Aug 19, 1915,</u>                                                                                                               |                                                                                              |
| DATE OF BIRTH                                                                                    |                                                                                      | that I last saw h <u>e</u> alive on <u>Aug 19, 1915,</u>                                                                                            |                                                                                              |
| <u>July 20, 1890</u><br>(Month) (Day) (Year)                                                     |                                                                                      | and that death occurred, on the date stated above, at <u>3 P.</u> m.                                                                                |                                                                                              |
| AGE                                                                                              |                                                                                      | The CAUSE OF DEATH* was as follows:                                                                                                                 |                                                                                              |
| <u>25 yrs. 1 mos. ds.</u> IF LESS than 1 day, ____ hrs. or ____ min.?                            |                                                                                      | <u>Typhoid fever</u>                                                                                                                                |                                                                                              |
| OCCUPATION                                                                                       |                                                                                      | <u>99R</u> <u>01</u>                                                                                                                                |                                                                                              |
| (a) Trade, profession, or particular kind of work <u>Housewife</u>                               |                                                                                      | (Duration) ____ yrs. ____ mos. ____ ds.                                                                                                             |                                                                                              |
| (b) General nature of industry, business, or establishment in which employed (or employer) _____ |                                                                                      | Contributory <u>Typhoid fever</u>                                                                                                                   |                                                                                              |
| BIRTHPLACE (City or town, State or foreign country) <u>Sedalia, Mo.</u>                          |                                                                                      | (Duration) ____ yrs. ____ mos. ____ ds.                                                                                                             |                                                                                              |
| PARENTS                                                                                          | NAME OF FATHER <u>Geo. McLaughlin</u>                                                | (Signed) <u>Edw. A. Arthur</u> M. D.                                                                                                                |                                                                                              |
|                                                                                                  | BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>St. Marys, Ohio</u> | <u>Aug 23, 1915</u> (Address) <u>Sedalia Mo</u>                                                                                                     |                                                                                              |
|                                                                                                  | MAIDEN NAME OF MOTHER <u>Nellie Ratterfield</u>                                      | *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. |                                                                                              |
|                                                                                                  | BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Piqua, Ohio</u>     | LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)                                                                  |                                                                                              |
| THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE                                                    |                                                                                      | At place of death ____ yrs. ____ mos. ____ ds. In the: ____ State ____ yrs. ____ mos. ____ ds.                                                      |                                                                                              |
| (Informant) <u>Edw. McLaughlin</u>                                                               |                                                                                      | Where was disease contracted if not at place of death? _____                                                                                        |                                                                                              |
| (ADDRESS) <u>Sedalia Mo</u>                                                                      |                                                                                      | Former or usual residence _____                                                                                                                     |                                                                                              |
| Filed <u>Aug 21, 1915</u> <u>W. B. Lucas</u> REGISTRAR                                           |                                                                                      | PLACE OF BURIAL OR REMOVAL <u>Crown Hill</u>                                                                                                        |                                                                                              |
|                                                                                                  |                                                                                      | DATE OF BURIAL <u>Aug 22, 1915</u>                                                                                                                  |                                                                                              |
|                                                                                                  |                                                                                      | UNDERTAKER <u>McLaughlin Bros.</u>                                                                                                                  |                                                                                              |
|                                                                                                  |                                                                                      | ADDRESS <u>Sedalia, Mo.</u>                                                                                                                         |                                                                                              |

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|                                                                                                                                                             |               |                                                                                                                                                                                                                                                               |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>PLACE OF DEATH</b><br>County.....<br>Township.....<br>or<br>Village.....<br>or<br>City.....                                                              |               | <b>MISSOURI STATE BOARD OF HEALTH</b><br><b>BUREAU OF VITAL STATISTICS</b><br><b>CERTIFICATE OF DEATH</b><br>Registration District No. .... File No. ....<br>Primary Registration District No. .... Registered No. ....<br>City..... (NO. .... St. .... Ward) |  |
| <b>FULL NAME</b>                                                                                                                                            |               |                                                                                                                                                                                                                                                               |  |
| <b>PERSONAL AND STATISTICAL PARTICULARS</b>                                                                                                                 |               |                                                                                                                                                                                                                                                               |  |
| SEX                                                                                                                                                         | COLOR OR RACE | SINGLE<br>MARRIED<br>WIDOWED<br>OR DIVORCED<br>(Write the word)                                                                                                                                                                                               |  |
| DATE OF BIRTH                                                                                                                                               |               | (Month) ..... (Day) ..... 191.....<br>If LESS than<br>1 day..... hrs.<br>or..... min. ?                                                                                                                                                                       |  |
| AGE                                                                                                                                                         |               | ..... yrs. .... mos. .... ds.                                                                                                                                                                                                                                 |  |
| OCCUPATION                                                                                                                                                  |               |                                                                                                                                                                                                                                                               |  |
| (a) Trade, profession, or particular kind of work .....<br>(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<br>(City or town, State or foreign country) .....                                                                                      |               |                                                                                                                                                                                                                                                               |  |
| MAIDEN NAME OF MOTHER                                                                                                                                       |               |                                                                                                                                                                                                                                                               |  |
| BIRTHPLACE OF MOTHER<br>(City or town, State or foreign country) .....                                                                                      |               |                                                                                                                                                                                                                                                               |  |
| THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) .....                                                                                          |               |                                                                                                                                                                                                                                                               |  |
| (ADDRESS) .....                                                                                                                                             |               |                                                                                                                                                                                                                                                               |  |
| Filed                                                                                                                                                       |               | 191.....                                                                                                                                                                                                                                                      |  |
|                                                                                                                                                             |               | REGISTRAR                                                                                                                                                                                                                                                     |  |

  

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|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------|--|
| <b>MEDICAL CERTIFICATE OF DEATH</b>                                                                                                                                                                                                                                                                                                                                                                                                     |  |                |  |
| DATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                |  |
| ..... 191..... (Month) ..... (Day) ..... 191.....                                                                                                                                                                                                                                                                                                                                                                                       |  |                |  |
| I HEREBY CERTIFY, that I attended deceased from<br>..... 191..... to ..... 191.....<br>that I last saw h..... alive on ..... 191.....<br>and that death occurred, on the date stated above, at ..... m.<br>The CAUSE OF DEATH* was as follows:<br>.....<br>.....<br>.....<br>..... (Duration) ..... yrs. .... mos. .... ds.<br>..... (Duration) ..... yrs. .... mos. .... ds.<br>(Signed) ..... M. D.<br>..... 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)<br>At place of death..... yrs. .... mos. .... ds. State ..... yrs. .... mos. .... ds.<br>Where was disease contracted if not at place of death?<br>Former or usual residence.....                                                                                                                                                                    |  |                |  |
| PLACE OF BURIAL OR REMOVAL                                                                                                                                                                                                                                                                                                                                                                                                              |  | DATE OF BURIAL |  |
| UNDERTAKER                                                                                                                                                                                                                                                                                                                                                                                                                              |  | ADDRESS        |  |