PLACE OF DEATH

County Cedar

Township ~~Box~~ or Village or City El Dorado Sp'gs

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

Registration District No. 163 File No. 639

Primary Registration District No. 4095 Registered No. 8

(No. ____ St.; ____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Sarah Gillette

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: white

SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): married

DATE OF BIRTH: March (Month) 16 (Day), 1837 (Year)

AGE: 79 yrs. 10 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):

BIRTHPLACE (City or town, State or foreign country): New Hampshire.

PARENTS
NAME OF FATHER: H. W. White
BIRTHPLACE OF FATHER (City or town, State or foreign country): Unknown.
MAIDEN NAME OF MOTHER: Munroe
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D. J. Gillette

(ADDRESS) El Dorado Sp'gs.

Filed 1 20 1916. W. O. Dawson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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DATE OF DEATH: January (Month) 19 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from November 16, 1915, to January 18, 1916, that I last saw her alive on January 18, 1916, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis
137 A
97

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

Contributory (SECONDARY) Bright's Disease

(Duration) ____ yrs. 3 mos. 2 ds.

(Signed) J. R. Williams, M. D.

Jan. 20, 1916 (Address) El Dorado Springs

*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: City Cem.

DATE OF BURIAL: 1 21 1916

UNDERTAKER: W. A. Stephens

ADDRESS: El Dorado Sp'gs

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

PLACE OF DEATH

County .....

Township .....
or
Village .....
or
City ..... (NO. ..... St.; ..... Ward)

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

[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

..... (Month) ..... (Day), *1*..... (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