

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.

PLACE OF DEATH

County Pettis

Township _____

or

Village _____

or

City Sedalia (NO. _____)Registration District No. 668File No. 11509Primary Registration District No. 3032Registered No. 80

St. _____ Ward _____

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

FULL NAME Sherman Roy Todd

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE <u>single</u> MARRIED WIDOWED OR SEVERED (Write the word)
DATE OF BIRTH <u>June 24 1893</u> (Month) (Day) (Year)		
AGE <u>23</u> yrs. mos. ds.		If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE

(City or town, State or foreign country) Pettis County

PARENTS

NAME OF FATHER J. J. ToddBIRTHPLACE OF FATHER Kentucky

(City or town, State or foreign country)

MAIDEN NAME OF MOTHER Leola J. MillerBIRTHPLACE OF MOTHER near Lake Camp

(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. J. Todd(ADDRESS) SedaliaFiled March 20 1916REGISTRAR H. B. LongMISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar 19 1916
(Month) (Day) (Year)

I HEREBY CERTIFY, that I have died deceased from Mar 4 1916 to Mar 19 1916
that I last saw him live on Mar 18 1916
and that death occurred, on the date stated above, at 4:30 m.

The CAUSE OF DEATH* was as follows:

(1) Para Hemiplegia due to Cerebral
Reliquity
34
820/11 (Duration) 3 mos. ds.

Contributory fees

(SECONDARY)

(Duration) unknown mos. ds.(Signed) Frank B. Long M. D.Mar 19 1916 (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 ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Cruzenberry CemeteryDATE OF BURIAL Mar 21 1916UNDERTAKER McKenzieADDRESS Sedalia

PLACE OF DEATH

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

County _____
Township _____
or _____
Village _____
or _____
City _____

Registration District No. _____
Primary Registration District No. _____

File No. _____
Registered No. _____

(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	(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)

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

REC

ADDRESS _____
DATE OF BURIAL _____ 191 _____
PLACE OF BURIAL OR REMOVAL _____
UNDERTAKER _____

COUNTY _____
TOWNSHIP _____
or _____
Village _____
or _____
City _____

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

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

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

Name of Dece _____ M. D. _____ (Address) _____
Single, Married _____ (Signed) _____

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

Date of Birth _____ (Duration) _____ yrs. _____ mos. _____ ds.

Age _____ Occupation _____

Birthplace _____ that I last saw him _____ alive on _____ 191 _____ to _____ 191 _____

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

The CAUSE OF DEATH* was as follows: _____

I HEREBY CERTIFY, that I attended deceased from _____ (City or _____) Birthplace of _____ Maiden name _____

DATE OF DEATH _____ (Month) _____ (Day) _____ (Year) _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____

Informant _____

Date Certificate _____

Date of Death _____

Cause of Death _____

Contributory _____

Name of attender _____

Place of burial _____

Name of under _____

Date of burial _____