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

18790

PLACE OF DEATH

County Pettis

Township Sedalia — Registration District No. 668 — File No.

or

Village — Primary Registration District No. ~~3 98~~ 5 889 — Registered No. 194

or

City — (No. — St. — Ward)

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

FULL NAME Wm Zeigle

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (If write the word)
M.	White	Widower

DATE OF BIRTH Sept 28 (Month) (Day), 1854 (Year)

AGE 62 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) Germany

PARENTS

NAME OF FATHER ✓

BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany

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) Theels Smith

(ADDRESS) Sedalia Mo

Filed May 8, 1916. H. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 5 (Month) 7 (Day), 1916 (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:

Carbolic acid poison

Suicide

163-D

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

Contributory (SECONDARY)

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

(Signed) D T Dyer M. D.

5/8 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 State ... yrs. ... mos. ... ds.

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

Former or usual residence ...

PLACE OF BURIAL OR REMOVAL Cole Camp Mo — DATE OF BURIAL 5/10 1916

UNDERTAKER MacKenzie — ADDRESS Sedalia Mo

PLACE OF DEATH

MISSOURI STATE BOARD
BUREAU OF VITAL STA
CERTIFICATE OF DEA

County.....

Township ..... Registration District No..... File No.....
or
Village..... Primary Registration District No..... Registered No.....
or
City ..... (NO. ....., ... St.; ..... Ward)

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., I.....
(Month) (Day) (Year)

AGE

If LESS than 1 day, ... hrs. or ..... min.?

..... yrs. ..... mos. ..... ds.

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 DEAT

DATE OF DEATH

.....
(Month)

I HEREBY CERTIFY, that I attende

....., 191...., to.....

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

and that death occurred, on the date stated abo

The CAUSE OF DEATH* was as follows:

.....

.....

.....(Duration).....yrs.....n

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....m

(Signed).....

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

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

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

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

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

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BU
UNDERTAKER	ADDRESS

Certificate of Death

[Approved by U. S. Consus and American Public Health Association.]

"Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial*

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e.g., *Farmer* or