

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                                                                                                                                                                                                             |                                                                            |                                                                                                           | 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>25365</u>     |  |
| Township _____<br>or _____                                                                                                                                                                                                 |                                                                            |                                                                                                           | Primary Registration District No. <u>3032</u>                                                | Registered No. <u>193</u> |  |
| City <u>Sedalia</u> (NO. <u>1812 S</u> <u>Junay</u> St.; _____ Ward)                                                                                                                                                       |                                                                            |                                                                                                           | [If death occurred in a hospital or institution, give its NAME instead of street and number] |                           |  |
| FULL NAME <u>In named daughter Robert Amos</u>                                                                                                                                                                             |                                                                            |                                                                                                           |                                                                                              |                           |  |
| PERSONAL AND STATISTICAL PARTICULARS                                                                                                                                                                                       |                                                                            |                                                                                                           |                                                                                              |                           |  |
| SEX<br><u>F</u>                                                                                                                                                                                                            | COLOR OR RACE<br><u>W</u>                                                  | SINGLE <u>—</u><br>MARRIED <u>—</u><br>WIDOWED <u>—</u><br>OR DIVORCED <u>—</u><br>(Write the word) _____ |                                                                                              |                           |  |
| DATE OF BIRTH <u>July 13, 1916</u><br>(Month) (Day) (Year)                                                                                                                                                                 |                                                                            |                                                                                                           |                                                                                              |                           |  |
| AGE<br><u>1</u> yrs. <u>1</u> mos. <u>1</u> ds.                                                                                                                                                                            |                                                                            | IF LESS than<br>1 day, _____ hrs.<br>or _____ min.?                                                       |                                                                                              |                           |  |
| OCCUPATION<br>(a) Trade, profession, or particular kind of work _____<br>(b) General nature of industry, business, or establishment in which employed (or employer) _____                                                  |                                                                            |                                                                                                           |                                                                                              |                           |  |
| BIRTHPLACE<br>(City or town, State or foreign country) <u>Sedalia Mo</u>                                                                                                                                                   |                                                                            |                                                                                                           |                                                                                              |                           |  |
| PARENTS                                                                                                                                                                                                                    | NAME OF FATHER <u>Robert Amos</u>                                          |                                                                                                           |                                                                                              |                           |  |
|                                                                                                                                                                                                                            | BIRTHPLACE OF FATHER<br>(City or town, State or foreign country) <u>Mo</u> |                                                                                                           |                                                                                              |                           |  |
|                                                                                                                                                                                                                            | MAIDEN NAME OF MOTHER <u>Mable Wry</u>                                     |                                                                                                           |                                                                                              |                           |  |
|                                                                                                                                                                                                                            | BIRTHPLACE OF MOTHER<br>(City or town, State or foreign country) <u>Mo</u> |                                                                                                           |                                                                                              |                           |  |
| THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE                                                                                                                                                                              |                                                                            |                                                                                                           |                                                                                              |                           |  |
| (Informant) <u>Robert Amos</u>                                                                                                                                                                                             |                                                                            |                                                                                                           |                                                                                              |                           |  |
| (ADDRESS) <u>Sedalia Mo</u>                                                                                                                                                                                                |                                                                            |                                                                                                           |                                                                                              |                           |  |
| Filed <u>July 14, 1916</u> <u>93</u> <u>P</u>                                                                                                                                                                              |                                                                            |                                                                                                           |                                                                                              |                           |  |
| MEDICAL CERTIFICATE OF DEATH                                                                                                                                                                                               |                                                                            |                                                                                                           |                                                                                              |                           |  |
| DATE OF DEATH <u>July 14, 1916</u><br>(Month) (Day) (Year)                                                                                                                                                                 |                                                                            |                                                                                                           |                                                                                              |                           |  |
| I HEREBY CERTIFY, that I attended deceased from <u>July 13, 1916</u> , to <u>July 14, 1916</u> , that I last saw her alive on <u>July 13, 1916</u> , and that death occurred, on the date stated above, at <u>10:15</u> m. |                                                                            |                                                                                                           |                                                                                              |                           |  |
| The CAUSE OF DEATH* was as follows:<br><u>Insufficient heart vent (Blue baby)</u><br><u>1570</u>                                                                                                                           |                                                                            |                                                                                                           |                                                                                              |                           |  |
| (Duration) _____ yrs. _____ mos. _____ ds.                                                                                                                                                                                 |                                                                            |                                                                                                           |                                                                                              |                           |  |
| Contributory<br>(SECONDARY)<br>(Duration) _____ yrs. _____ mos. _____ ds.                                                                                                                                                  |                                                                            |                                                                                                           |                                                                                              |                           |  |
| (Signed) <u>E. F. Staats</u> M. D.<br><u>July 15, 1916</u> (Address) <u>104 W. Main</u>                                                                                                                                    |                                                                            |                                                                                                           |                                                                                              |                           |  |
| *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. 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<br><u>Sedalia Mo</u>                                                                                                                                                                            |                                                                            |                                                                                                           | DATE OF BURIAL<br><u>July 14, 1916</u>                                                       |                           |  |
| UNDERTAKER<br><u>McLaughlin Bros.</u>                                                                                                                                                                                      |                                                                            |                                                                                                           | ADDRESS<br><u>Sedalia Mo</u>                                                                 |                           |  |
| REGISTRAR                                                                                                                                                                                                                  |                                                                            |                                                                                                           |                                                                                              |                           |  |

# PLACE OF DEATH

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

County \_\_\_\_\_  
Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_

Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_  
Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
City \_\_\_\_\_ (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<br>MARRIED<br>WIDOWED<br>OR DIVORCED<br>(Write the word) |
| DATE OF BIRTH _____ | (Month) _____ (Day) _____ (Year) _____ |                                                                 |
| AGE _____           | _____ yrs. _____ mos. _____ ds.        | IF LESS than<br>1 day, _____ hrs.<br>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 \_\_\_\_\_

### MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH \_\_\_\_\_  
(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<sup>y</sup> was as follows:

Contributory  
(SECONDARY)  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) \_\_\_\_\_, 191\_\_\_\_ (Address) \_\_\_\_\_ M. D.

\*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. 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 \_\_\_\_\_

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.