WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RE

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

PLACE OF DEATH

County Pettis

Township ____ or Village ____ or City Sedalia (NO. 1106 W. 6th St.; ____ Ward)

Registration District No. 668 File No. 28795

Primary Registration District No. 9032 Registered No. 215

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

FULL NAME James Thomas

PERSONAL AND STATISTICAL PARTICULARS

SEX Male

COLOR OR RACE White

~~SINGLE~~ MARRIED ~~WIDOWED~~ ~~OR DIVORCED~~ (~~Write the word~~) Married

DATE OF BIRTH June (Month) 5 (Day), 1838 (Year)

AGE 86 yrs. 1 mos. 26 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) ✓

BIRTHPLACE (City or town, State or foreign country) Pa.

PARENTS
NAME OF FATHER Geo. Thomas
BIRTHPLACE OF FATHER (City or town, State or foreign country) England
MAIDEN NAME OF MOTHER Susan Payne
BIRTHPLACE OF MOTHER (City or town, State or foreign country) England

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lucy Nadure

(ADDRESS) 1106 W. 6th

Filed Aug 2, 1916 F. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 1st (Month) (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from June 23, 1916, to Aug 1, 1916, that I last saw him alive on Aug 1st, 1916, and that death occurred, on the date stated above, at 4:00 p.m.

The CAUSE OF DEATH* was as follows:

Senility
No specific lesion evident.

(Duration) — yrs. 2 mos. — ds.

Contributory (SECONDARY) Cardiac paralysis

(Duration) — yrs. — mos. 1 ds.

(Signed) C. B. Trader M. D.

Aug 17, 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 Crown Hill

DATE OF BURIAL 8/2 1916

UNDERTAKER McKenzie

ADDRESS Sedalia

PLAINLY, WITH UNFA...

tions on statement of cause of death approved by Committee on Nomenclature of the American

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

PLACE OF DEATH

County.....

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

or

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

or

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 MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., *1*.....
(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)

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