MARGIN RESERVED FOR BINDING

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

27004

PLACE OF DEATH

County Macon

Township Liberty

or

Village

or

City Macon (NO. St.: Ward)

Registration District No. 533

Primary Registration District No. 5715

File No.

Registered No. 56

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

FULL NAME Andrew Nelson Sagaser

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

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

DATE OF BIRTH: Jan 1 (Month) (Day), 1861 (Year)

AGE: 57 yrs. 7 mos. 1 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): P.A.

PARENTS

NAME OF FATHER: John Jacob Sagaser

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

MAIDEN NAME OF MOTHER: Elizabeth Slater

BIRTHPLACE OF MOTHER (City or town, State or foreign country): [illegible]

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. A. M. Sagaser

(ADDRESS) Callao Mo RTO

Filed 8-10-, 1918. [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

DATE OF DEATH: Aug 1 (Month) (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from May 7th, 1918, to Aug 1, 1918, that I last saw him alive on Aug 1, 1918, and that death occurred, on the date stated above, at 3:20 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

131

97

120

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

8 Contributory (SECONDARY) Arteriosclerosis

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

(Signed) L. C. Mason M. D.

Aug 7, 1918 (Address) Bowen

*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: Belenger Graveyard

DATE OF BURIAL: Aug 2, 1918

UNDERTAKER: Albert Shinner

ADDRESS: Macon Mo

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

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

..... (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

..... (Month) ..... (Day) ..... 191 (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