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 Hickory

Township Center

or

Village ~~Hermitage~~

or

City _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. 360

Primary Registration District No. 5505

File No. 24910-C

Registered No. 1

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

FULL NAME Sarah Catherine Odenbaugh

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Married

DATE OF BIRTH Mch (Month) 10 (Day), 1887 (Year)

AGE 32 yrs. 5 mos. 16 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country) Nebraska

PARENTS
NAME OF FATHER Chas. B. Fiedler
BIRTHPLACE OF FATHER (City or town, State or foreign country) U.S.
MAIDEN NAME OF MOTHER Tillotson
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Iowa

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. J. Odenbaugh

(ADDRESS) Hermitage, Mo.

Filed Sept, 1919. J. H. Crouch REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug (Month) 26 (Day), 1919 (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 15, 1919, to Aug 26, 1919, that I last saw her alive on Aug 26, 1919, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Peritonitis
122B
129

117

(Duration) ___ yrs. ___ mos. 7 ds.

Contributory (SECONDARY) Locked bowels

(Duration) ___ yrs. ___ mos. 3 ds.

(Signed) W. S. Woodford M. D.

Aug 27, 1919 (Address) Cross Timbers 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 Clark Cem - near Hermitage

DATE OF BURIAL Aug 27, 1919

UNDERTAKER None

ADDRESS Hermitage Mo

PLACE OF DEATH

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

County .....

Township ..... Registration District No. 360, 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

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.