LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

12580c

PLACE OF DEATH
County: Howell — Registration District No. 387 — File No.
Township: Dry Creek — Primary Registration District No. 5540 — Registered No.
City: Pomona (No. ..., St. ..., Ward)

FULL NAME: Sarah Emmiline Wildman

(a) Residence. No. ..., St., ..., Ward. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U.S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Married

MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF: Ira H Wildman

DATE OF BIRTH (MONTH, DAY AND YEAR): June 23 - 1852

AGE: YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ... min.
70	9	21	

OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

BIRTHPLACE (CITY OR TOWN): Indianapolis
(STATE OR COUNTRY): Mahaska Co Iowa

NAME OF FATHER: Felix Conner

BIRTHPLACE OF FATHER (CITY OR TOWN):
(STATE OR COUNTRY): Indiana.

MAIDEN NAME OF MOTHER: Betsy Harcourt

BIRTHPLACE OF MOTHER (CITY OR TOWN):
(STATE OR COUNTRY):

INFORMANT: I. H. Wildman
(Address): West Plains Mo

FILED: 5/20, 1923 — A. P. Cottrell, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): April 14 - 1923

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to April 14, 1923 that I last saw her alive on April 9, 1923, and that death occurred, on the date stated above, at 1:15 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Diabetes mellitus
59
Probably (duration) 12 yrs. ... mos. ... ds.
CONTRIBUTORY (SECONDARY): Endo Carditis - Sudden dilatation (duration) several yrs. ... mos. ... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? —
DID AN OPERATION PRECEDE DEATH? No. DATE OF —
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? General Findings
(Signed) D. D. Cox, M. D
4-14-, 1923 (Address) Pomona Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: MacKay Cemetery — DATE OF BURIAL: 4/15 - 1923
20. UNDERTAKER: R. Burns — ADDRESS: Willow Springs Mo

V. S. No. 2.

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.

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and Stat

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

17.
I HEREBY CERTIFY, That I attended deceased from .....
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death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)
.....(duration).....yrs. .....mos.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed).....
, 19 (Address)

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20. UNDERTAKER	ADDRESS