

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

Do not use this space.

37282

JAN 18 1928
1. PLACE OF DEATH
County Jasper
Township
City Brunswick (No. _____) (St. _____) (Ward _____)

Registration District No. 416
Primary Registration District No. 4248

File No. _____
Registered No. 19

2. FULL NAME Maudie L. Seibert
(a) Residence, No. Eight St St., _____ Ward. _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U.S., if of foreign birth? 2 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 2, 1872
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
55 10 9

8. 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) 11
(c) Name of employer Crown house

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

10. NAME OF FATHER Geo. Davis

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

12. MAIDEN NAME OF MOTHER Stumpfe
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Campana
(STATE OR COUNTRY) Iowa

14. INFORMANT Dr. J. J. Davis
(Address) Springfield, Mo.

15. FILED 12/12/27 L. J. Simmons REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec - 11 1927

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1927, to Dec 11 1927, and that I last saw her alive on Dec 11 1927, and that death occurred, on the date stated above, at 11:20 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of breast

50 (duration) 1 yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 47 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED? X
IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? yes DATE OF Feb. 1927

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Laboratory
(Signed) L. J. Simmons, M. D.
12/12, 1927 (Address) Springfield, 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Springfield DATE OF BURIAL Dec 14 1927

20. UNDERTAKER Springfield ADDRESS Springfield

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Gasper Registration District No. 416 File No. _____
 Township _____ Primary Registration District No. 4248 Registered No. 19
 City Saucoy (No. _____) St. _____ Ward _____

2. FULL NAME Maudie L Sabert

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

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

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

F W M

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 _____ (duration) _____ yrs. _____ mos. _____ ds.
 (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)

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 Dec 27 1927 Levy Simons REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 11 1927

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ after on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

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) _____, M. D. _____, 19____ (Address)

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

AS PRESCRIBED BY LAW
RE
N
NOT RECEIVE A FEE FOR CERTIFICATES U.
MORTUARY

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