

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

Do not use this space.

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1. PLACE OF DEATH

County HaskellRegistration District No. 384Township West PlainsPrimary Registration District No. 4777City West Plains (No. _____) St. _____ Ward _____File No. 34

Registered No. _____

St. _____ Ward _____

2. FULL NAME

Sally B. Proutte

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widow

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

James P. Proutte

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

Oct 13

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

83119

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)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

North York

(STATE OR COUNTRY)

Va

10. NAME OF FATHER

Basley Rut

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Sturges

12. MAIDEN NAME OF MOTHER

Elizabeth Henderson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

S. Carolina

14. INFORMANT

Martha Watson

(Address)

Sum Colorado

15. FILE NO.

4-27-28 O.P.A. Heurich

REGISTRAR

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

4-20 1928

17.

I HEREBY CERTIFY, That I attended deceased from 3-13, 1928, to 4-2, 1928, that I last saw him alive on 4-7, 1928, and that death occurred, on the date stated above, at 11:00 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Chronic Inter-Nephritis

CONTRIBUTORY (SECONDARY)

Fracture of Femur (duration) 3 yrs. - 4 mos. - 4 ds.(duration) 2 yrs. - 4 mos. - 19 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:

(Signed) P. D. Gunn M. D., 19 (Address) West Plains, 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

DATE OF BURIAL

Dropping Spring 4-3 1928

20. UNDERTAKER

ADDRESS

McFarland and Co West Plains Mo

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

ALL INFORMATION REQUESTED
HEREIN MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Howell Registration District No. 384 File No. _____
 Township _____ Primary Registration District No. 4227 Registered No. 34
 City West Plains No. _____ St. _____ Ward _____

2. FULL NAME

Sallie C. Privette
 (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 13 1840

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) _____

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) 4-2 19 28

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Interstitial Nephritis

CONTRIBUTORY Fracture of Femur
 (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 _____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED

1928-4-2
83-2-13
1845-1-19

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