

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

Do not use this space.

Bohling
28127

1. PLACE OF DEATH

County *De Witt*
Township *Sedalia*
City *Sedalia* (No. _____)

Registration District No. *668*
Primary Registration District No. *9032*

File No. _____
Registered No. *222*
St. _____ Ward _____

2. FULL NAME

Thomas Montgomery
(a) Residence No. *1510 S. Grand* 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 7 - 1845*

7. AGE YEARS *83* MONTHS _____ DAYS *3* IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Farmer*
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) *Frankfort*
(STATE OR COUNTRY) *Kentucky*

10. NAME OF FATHER *John Montgomery*

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

12. MAIDEN NAME OF MOTHER *Reinick's*
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Frankfort*
(STATE OR COUNTRY) *Kentucky*

14. INFORMANT *A. L. Montgomery*
(Address) *San Bonito Cal.*

15. FILED *8. 31. 28* *J. J. Love*
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Aug 6 1928*

17. I HEREBY CERTIFY That I attended deceased *July 20th 1928* to *Aug 6th 1928* that I last saw him alive on *Aug 3rd 1928* and that death occurred, on the date stated above, at *12 a* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
acute Dysentery
99 non-amedic
130

CONTRIBUTORY (SECONDARY) *Arterio Sclerosis*
(duration) *15* yrs. mos. da.

910 (duration) *6* yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED? *NOT AT PLACE OF DEATH*

0 DID AN OPERATION PRECEDE DEATH? *no* DATE OF _____

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS *clinical symptoms*
(Signed) *Bohling*, M. D.

Aug 30, 1928 (Address) *Sedalia 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 *Crown Hill* DATE OF BURIAL *Aug 8 1928*

20. UNDERTAKER *Lilleaspie Mtd. Co.* ADDRESS *Sedalia*

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. WRITE PLAINLY, WITH OBTAINING INFORMATION AS A PRIMARY CONCERN.

