

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

Do not use this space.

34038

1. PLACE OF DEATH

County Knox Registration District No. 444
 Township Knox City Primary Registration District No. 4262
 City Knox City No. _____ St. _____ Ward _____

File No. _____

Registered No. 155

2. FULL NAME

Salona Baxter
 (a) Residence. No. Robelle 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 Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Benjamin Baxter
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar-21-1840
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
88 | 6 | 12 | _____
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housekeeper
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 3 1928
 17. I HEREBY CERTIFY That I attended deceased from Aug 24 1928 to Oct 3 1928 that I last saw her alive on Sept 29 1928, and that death occurred, on the date stated above, at _____
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
fracture of R hip
 _____ (duration) yrs. mos. ds. 34
 CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds. _____

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

10. NAME OF FATHER Alfred Sullivan
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Ohio
 12. MAIDEN NAME OF MOTHER Sarah Fountain
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Delaware

14. INFORMANT William Sullivan (Address) Robelle

15. FILED Oct 4 1928 J.R. Northcutt REGISTRAR

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) Alfred McKeyhold M. D.
Oct 3 1928 (Address) Temp City 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 Robelle Cemetery DATE OF BURIAL Oct 4 1928
 20. UNDERTAKER Gett & Brooks ADDRESS Monro, Mo

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.

NOV 22 1928

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Knox
Township
City Knox City

Registration District No. 444
Primary Registration District No. 4262

File No.
Registered No. 15
St. Ward

2. FULL NAME

(a) Residence, No. Salona Baxter 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) Wid

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)

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

Oct 28, 1928 J. R. Northcott
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 3 1928

17. I HEREBY CERTIFY That I attended deceased from 19....., 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:

Fracture of R. Hip
Fall from a chair
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED (duration) yrs. mos. ds.

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

WIFE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-34638