

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

Do not use this space.

2 1929

1. PLACE OF DEATH

County Saline Registration District No. 744 File No. 13426
 Township Cambridge Primary Registration District No. 4476 Registered No. 6
 City Gilman (No.) St. Ward

2. FULL NAME

William Sewell
 (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 male **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 Mrs Sewell

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 25 - 1844

7. AGE: YEARS 82 MONTHS 2 DAYS 12 If LESS than 1 day, hrs. or min.

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

9. BIRTHPLACE (CITY OR TOWN) Putman Co
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Wm Sewell

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)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 7 - 19 19

17. I HEREBY CERTIFY That I attended deceased from 2-10 1929, to 2-4 1929 that I last saw h. alive on 2-8 1929 and that death occurred, on the date stated above, at 7:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Exhaustion of heart
40 535
 (duration) 2 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (SECONDARY) None
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH. ✓

19. DID AN OPERATION PRECEDE DEATH? no. DATE OF ✓

20. WAS THERE AN AUTOPSY? no.

WHAT TEST CONFIRMED DIAGNOSIS? Electrocardiogram
 (Signed) W. J. Anderson, M. D.
8-4, 1929 (Address) Gilman Mo

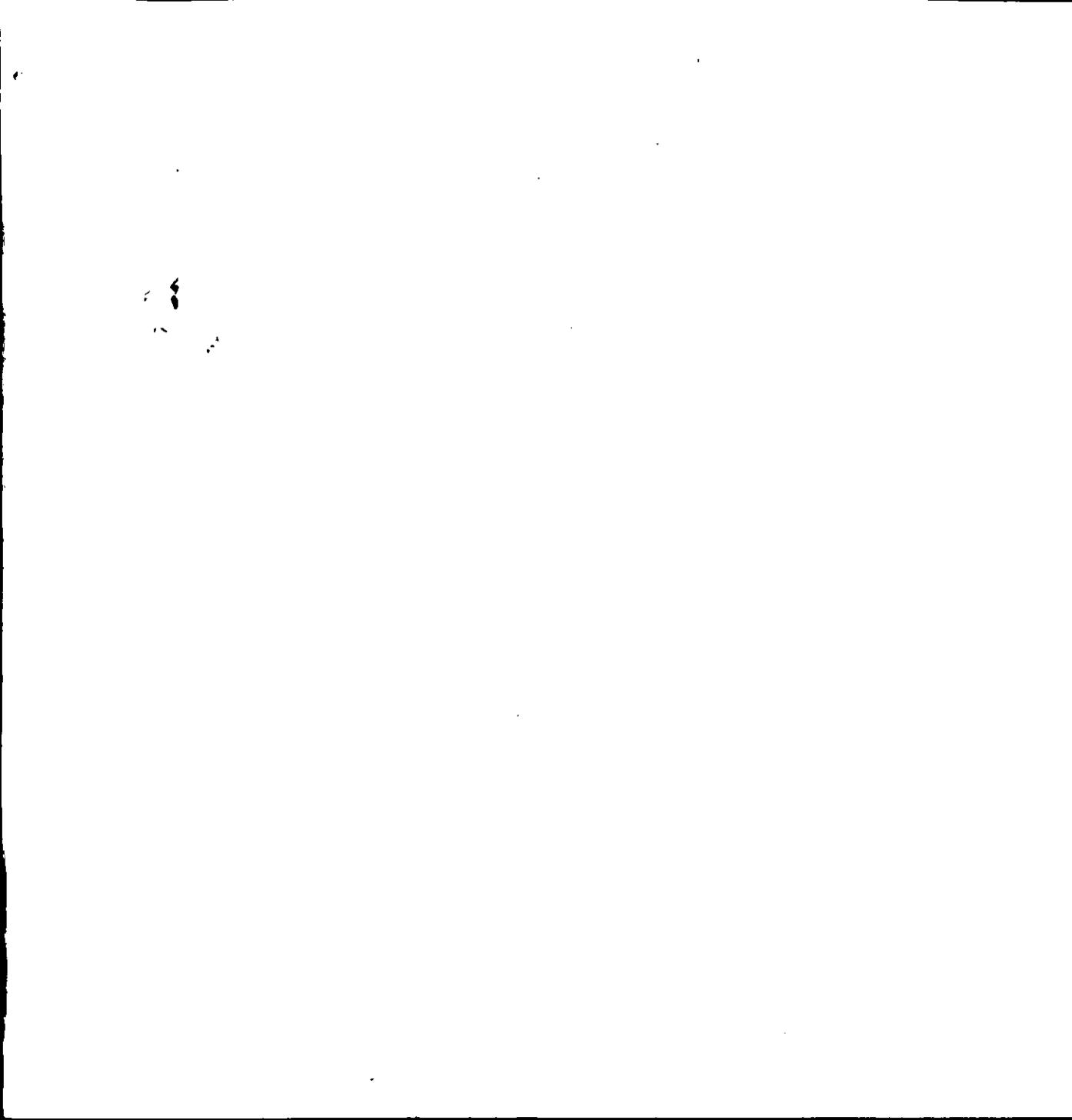
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Gilman mo **DATE OF BURIAL** May 9 19 29

20. UNDERTAKER Jones & Saezen **ADDRESS** Stater mo

14. INFORMANT Mrs. Wm Sewell
 (Address) Gilman mo

15. FILED 2-9-29 1929 W. J. Anderson REGISTRAR



**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 Saline

Registration District No. 7.94

File No. _____

Township _____

Primary Registration District No. 4473-

Registered No. 3

City Billion

(No. _____)

St. _____ Ward _____

2. FULL NAME

William Levell

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) 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 _____

(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) un known

12. MAIDEN NAME OF MOTHER un known

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

14. INFORMANT (Address) _____

15. FILED 3-5-29 J. J. Davidson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/7 1929

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

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 _____

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

SUPPLEMENTARY

S-13426