

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

Do not use this space.

14941

**1. PLACE OF DEATH**

County Wheeler Registration District No. 399  
 Township Rain Primary Registration District No. 1002  
 City Lawrence City (No. St. Marys) St. 1986 Ward

File No. \_\_\_\_\_  
 Registered No. \_\_\_\_\_  
 St. 1986 Ward

**2. FULL NAME**

(a) Residence No. 1017 E. Linwood Blvd. 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 1, 1900

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
28 9 28

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Secretary  
 (b) General nature of industry, business, or establishment in which employed (or employer) Laundries System  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Worthman  
 (STATE OR COUNTRY) Tex.

10. NAME OF FATHER Lee Sattenwhite

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

12. MAIDEN NAME OF MOTHER Bessie Weaver

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

14. INFORMANT W. W. Bender  
 (Address) 1017 E. Linwood Blvd.

15. FILED 4/29/29 M. M. Crowe  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 29 1929

17. I HEREBY CERTIFY, That I attended deceased from Apr 22/29 19\_\_\_\_ to Apr 29 19\_\_\_\_ that I last saw her alive on Apr 29 19\_\_\_\_ and that death occurred, on the date stated above, at 5:50 P.M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Streptococcus Peritonitis  
12/11  
12/9

CONTRIBUTORY (SECONDARY) Streptococcus Appendicitis

from Apr 19 (duration) yrs. mos. 7 ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH Berkshire Arms Hotel

1 DID AN OPERATION PRECEDE DEATH? Yes DATE OF Apr 22/29

WAS THERE AN AUTOPSY? No

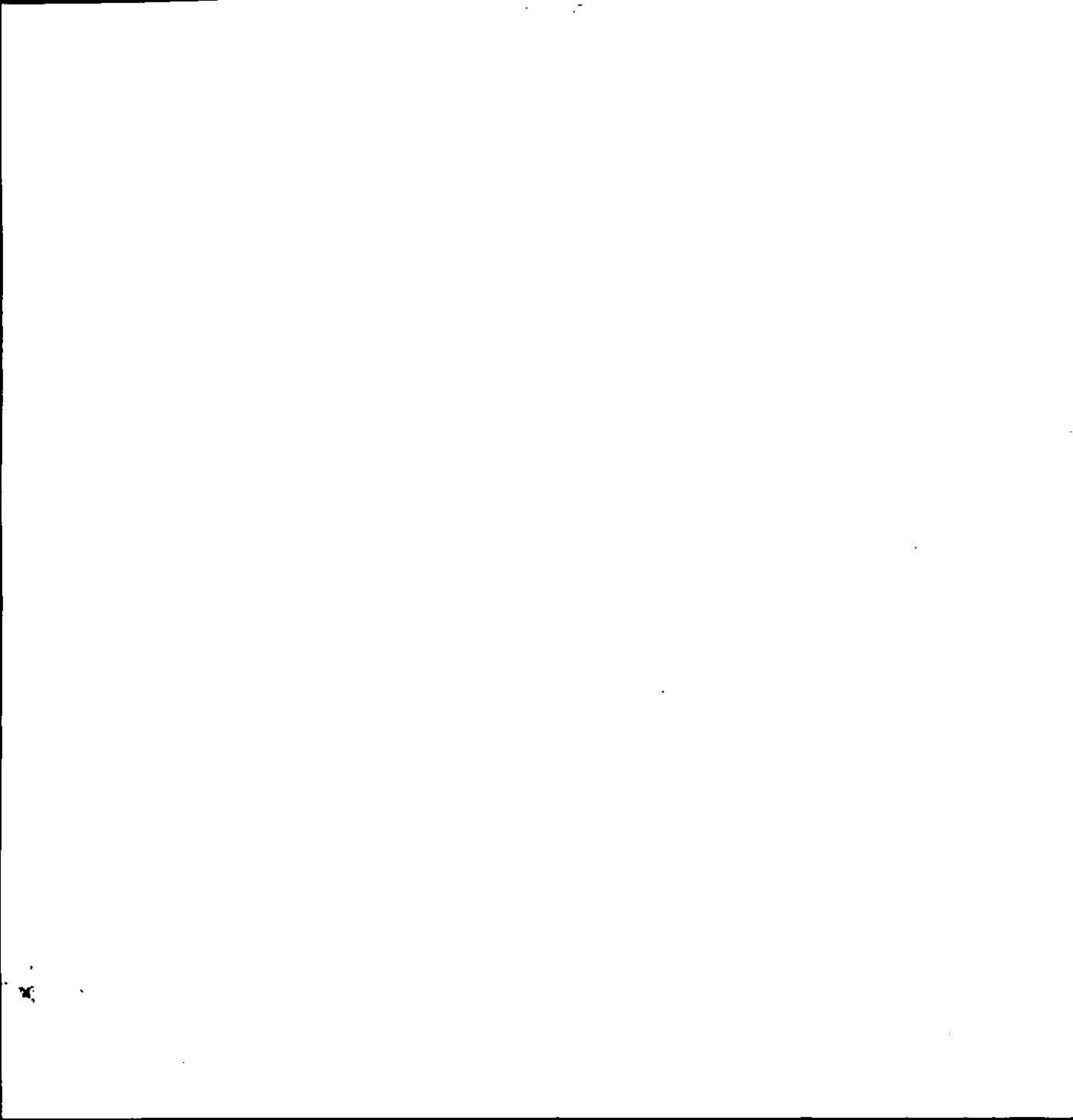
WHAT TEST CONFIRMED DIAGNOSIS? Clinical  
 (Signed) #9 McQuinn, M. D.

4-29-29 (Address) 1002 Medical Bldg Bldg

\*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 Parkdale, Tex. DATE OF BURIAL 4/30/29

20. UNDERTAKER Greenman Mortuary ADDRESS 104 W. 4th St.



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County..... Registration District No..... File No.....  
 Township..... Primary Registration District No..... Registered No. 1986  
 City..... (No. St. Marys Hospital St. .... Ward)

**2. FULL NAME**

(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) .....

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 4/29 29 M.M. Browe REGISTRAR  
Assn

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-29-29

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

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Streptococcus Peritonitis  
operation for acute appendicitis

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

18. WHERE WAS DISEASE CONTRACTED .....

IF NOT AT PLACE OF DEATH .....

DID AN OPERATION PRECEDE DEATH? Yes.. DATE OF 4-22-29

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 .....

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

**SUPPLEMENTARY**

S-14941