

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

Do not use this space.

*B. 31549*

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.

80  
88  
55  
241929

1. PLACE OF DEATH *Pettis*  
 County *Pettis* Registration District No. *668*  
 Township *Sedalia* Primary Registration District No. *3032*  
 City *Sedalia* (No. *620*) *3 Wash* St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME *William J Claggett*  
 (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) *Married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *June 10-1875*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
*54 3 3*

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) *Ky*

PARENTS

10. NAME OF FATHER *James Claggett*

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

12. MAIDEN NAME OF MOTHER *Elva Shelton*

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

14. INFORMANT *Mrs W J Claggett*  
 (Address) *Sedalia*

15. FILED *9-14-29* 19 *29*  
*J. S. Love* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 13 1929*

17. I HEREBY CERTIFY, That I attended deceased from *Sept 7* to *Sept 13*, 19*29*, that I last saw him alive on *Sept 13*, 19*29*, and that death occurred, on the date stated above, at *9 P* m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Mitral Insufficiency*  
*133C*

CONTRIBUTORY (SECONDARY) *Acute Suppression of Urine*  
 (duration) *2* yrs. mos. ds.  
 (Cause unknown) (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? *no*  
 WHAT TEST CONFIRMED DIAGNOSIS *Phys. Exam*  
 (Signed) *W. B. Beckman* M. D.  
 , 19 (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 *Sedalia* DATE OF BURIAL *Sept 14 1929*

20. UNDERTAKER *Telephia* ADDRESS *Sedalia*

