

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

Do not use this space.

40331

1. PLACE OF DEATH

County Greene Registration District No. 318
 Township..... Primary Registration District No. 2081
 City Springfield, Mo. (No. 535 E. Monroe) St. _____ Ward _____

File No. _____
 Registered No. 919

2. FULL NAME James B. Sivewright

(a) Residence. No. 535 E. Monroe 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 <u>Letha Sivewright</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>No. Exact Data</u>				
7. AGE <u>about 57</u>	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Boiler Maker</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer <u>Heer Store</u>				
9. BIRTHPLACE (CITY OR TOWN) <u>Palistine</u> (STATE OR COUNTRY) <u>Texas</u>				

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec, 15 1929

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him dead Dec. 15, 1929, and that death occurred, on the date stated above, at 2:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Coronary Sclerosis
91B
1150
 (duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY acute indigestion
 (SECONDARY)
 (duration) _____ yrs. _____ mos. _____ da.

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

DID AN OPERATION PRECEDE DEATH? how DATE OF _____

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) James C. Stone, M. D.
Dec 15, 1929 (Address) Springfield, 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 East Lawn. DATE OF BURIAL Dec 17 1929

20. UNDERTAKER Anna Schweyer. ADDRESS Springfield Missouri

10. NAME OF FATHER James Sivewright

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

12. MAIDEN NAME OF MOTHER McKee

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

14. INFORMANT Thos Letha Sivewright
 (Address) Springfield, Mo

15. FILED 12-17-29 John Sharp REGISTRAR

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.

WHILE LIVING WITH CONTRACTING PARTIES IS A PERMANENT RECORD

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