

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

Do not use this space.

549

1. PLACE OF DEATH

County Clay Registration District No. 209
Township Liberty Primary Registration District No. 5080
City No. _____ St. _____ Ward _____

File No. _____
Registered No. 7

2. FULL NAME

Colonel Jasper Sales
(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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 25-1925

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
5 | 0 | 7

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) Liberty
(STATE OR COUNTRY) Mo

10. NAME OF FATHER Andrew J. Sales

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Bartholomew Co. Mo
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Cora B. Spay

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Little Sioux
(STATE OR COUNTRY) Iowa

14. INFORMANT Cora B. Spay
(Address) Liberty, Mo

15. FILED 7/29/30 Wm H Goodson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 27 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1929 to Jan 29 1930
that I last saw h. in allve on Jan 26 1930, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Acidosis & lack of care

109B (Not diabetic)
194B (duration) yrs. mos. ds.

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

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? symptoms
(Signed) Wm H Goodson M. D.
7/28/30 (Address) Liberty 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 Fairview Liberty Mo DATE OF BURIAL 1/28/30
1930

20. UNDERTAKER Wm H Goodson ADDRESS Liberty Mo

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.

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