

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

Do not use this space.  
4338

MAR 25 1930  
 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.

1. PLACE OF DEATH  
 County Cass Registration District No. 1576 File No. \_\_\_\_\_  
 Township Grand River Primary Registration District No. 5249 Registered No. 9  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Susan Badgley  
 (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 26 yrs. — mos. — da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>		
5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF _____ (OR) WIFE OF <u>Isaac N Badgley</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>April 21 - 1845</u>				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>84</u>	<u>9</u>	<u>13</u>	
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Home maker</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____				

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/4 1930

17. I HEREBY CERTIFY, That I attended deceased from 1-26, 1930, to 2-4, 1930, that I last saw her alive on 2-3, 1930, and that death occurred, on the date stated above, at 3:10 a. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Lobar Pneumonia

CONTRIBUTORY (SECONDARY) 101W (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH: \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH: \_\_\_\_\_ DATE OF \_\_\_\_\_

20. WAS THERE AN AUTOPSY \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS:  
 (Signed) David S Long, M. D.  
2/4, 1930 (Address) Halle 200

\*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.

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Eric Sartman

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Sarah Riley

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Kentucky

14. INFORMANT E. A. Williams  
 (Address) Shamrock, Texas

15. FILED 7/4, 1930 D. S. Long REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL <u>Orient</u>	DATE OF BURIAL <u>7/5</u> 19 <u>30</u>
20. UNDERTAKER <u>Rummenburg Bros Co</u>	ADDRESS <u>Harrisonville</u>

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