

TE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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

Do not use this space.

4520

1. PLACE OF BIRTH

County Spent
Township Saline Mo.
City Saline Mo.

Registration District No. 266
Primary Registration District No. 4167

File No. _____
Registered No. 90
St. _____ Ward) _____

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward. _____
(Usual place of abode)
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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Nancy Jane Peddon

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 18-1832

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
97 3 24

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Washington Co Tenn.
(STATE OR COUNTRY)

10. NAME OF FATHER not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN) not known
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) not known
(STATE OR COUNTRY)

14. INFORMANT Mrs B Backwell
(Address) Saline Mo

15. FILED 2/14 1930 W. E. Rudd, M.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/12 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1929 to Feb 14 1930
that I last saw him alive on Feb. 12, 1930 and that death occurred, on the date stated above, at 6 PM.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Fractured hip. 1864
1929
from Nov. (duration) about 15 yrs. 2 mos. ds.

CONTRIBUTORY (SECONDARY) Old age
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH X
DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. C. Welch, M. D.

. 19 (Address) Saline 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 Union Cemetery DATE OF BURIAL 2/14 30

20. UNDERTAKER W. E. Rudd ADDRESS Saline Mo

THE NAME OF THE PERSON WHO SHOULD BE CONTACTED FOR MORE INFORMATION SHOULD BE PROVIDED. THE NAME OF THE PERSON WHO SHOULD BE CONTACTED FOR MORE INFORMATION SHOULD BE PROVIDED. THE NAME OF THE PERSON WHO SHOULD BE CONTACTED FOR MORE INFORMATION SHOULD BE PROVIDED.

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

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County CentRegistration District No. 266

File No. _____

Township _____

Primary Registration District No. 4164Registered No. 90City Salem

(No. _____) 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

m

4. COLOR OR RACE

w5. SINGLE, MARRIED, WIDOWED OR
DIVORCED (write the word)wid5A. 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

3/12/30 WE Ruedmo

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 12 1930

17.

I HEREBY CERTIFY, That I attended deceased from _____, 19____,

that I last saw him _____, 19____, and that

death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Fractured hip
accidental fallCONTRIBUTORY
(SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

DID AN OPERATION PRECEDE DEATH? DATE OF _____

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

19

20. UNDERTAKER

ADDRESS

S-4520

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PC