

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.

MAY 27 1930

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

Do not use this space.

File No. *13558*  
Registered No. *95*  
St. \_\_\_\_\_ Ward \_\_\_\_\_

1. PLACE OF DEATH

County *Pitts*  
Township \_\_\_\_\_  
City *Jedalia*

Registration District No. *668*  
Secondary Registration District No. *3932*  
(No. *Hospital*)

2. FULL NAME

(a) Residence. No. *Wassaw mo* 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 <i>F</i>	4. COLOR OR RACE <i>W</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Single</i>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Mar 27 1915</i>				
7. AGE	YEARS <i>15</i>	MONTHS	DAYS <i>7</i>	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				

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Apr 3 1930*

17. I HEREBY CERTIFY, That I attended deceased from *Mar 30* 1930, to *Apr 3* 1930, that I last saw him alive on *Apr 3* 1930, and that death occurred, on the date stated above, at \_\_\_\_\_ p. *a* m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Appendicitis*  
*12 1/2*  
*12* general (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *Pertinents* (duration) yrs. mos. ds. *4*

18. WHERE WAS DISEASE CONTRAICTED *117 B*

IF NOT AT PLACE OF DEATH, \_\_\_\_\_

1 DID AN OPERATION PRECEDE DEATH? *yes* DATE OF *Apr 30 1930*

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_

(Signed) *M. P. Sly* M. D.  
, 19 \_\_\_\_\_ (Address) *Jedalia 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.

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

10. NAME OF FATHER *J. E. Sartor* *mo*

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

12. MAIDEN NAME OF MOTHER *Annie Fowler* *mo*

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

14. INFORMANT *J. E. Sartor* *mo*  
(Address) *Wassaw mo*

15. FILED *4-7-30* 19 *30* *J. H. Love* REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Wassaw mo* DATE OF BURIAL *4/4 1930*

20. UNDERTAKER *Sellspier* ADDRESS *Jedalia*

