

SEP 24 1930

# MISSOURI STATE BOARD OF HEALTH

## BUREAU OF VITAL STATISTICS

### CERTIFICATE OF DEATH

Do not use this space.

## 1. PLACE OF BIRTH

County

Township

City

Registration District No.

Primary Registration District No.

(No.

File No.

Registered No.

St.

Ward)

## 2. FULL NAME

(a) Residence No.

(Usual place of abode)

St.

Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs.

mos.

ds.

How long in U.S., if of foreign birth? 70 yrs. 3 mos. 9 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

Sallie E. Sims

## 6. DATE OF BIRTH (MONTH, DAY AND YEAR)

## 7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

70

3

3

## 8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Hlwr. Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Himself

## 9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Illinois

## 10. NAME OF FATHER

Wm Sims

## 11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

David Kneass

## 12. MAIDEN NAME OF MOTHER

David Kneass

## 13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

David Kneass

## 14. INFORMANT

(Address)

Sallie E. Sims  
Ulrich Mo

## 15. FILED

8/20, 1930

L.H. E.C. Peelor

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH (MONTH, DAY AND YEAR)

Aug 16 1930

## 17.

I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to Aug 16, 1930, that I last saw him alive on Aug 16, 1930, and that death occurred, on the date stated above, at 3:30 P.M.

## THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Pulmonary Tuberculosis

T.B.A.

(duration) 2 yrs. ? mos. ds.

## CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

## 18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

0 DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Microscope

(Signed) J. S. McDonald, M.D.

, 19 (Address) Ulrich 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

Hickory Grove Cemetery

## DATE OF BURIAL

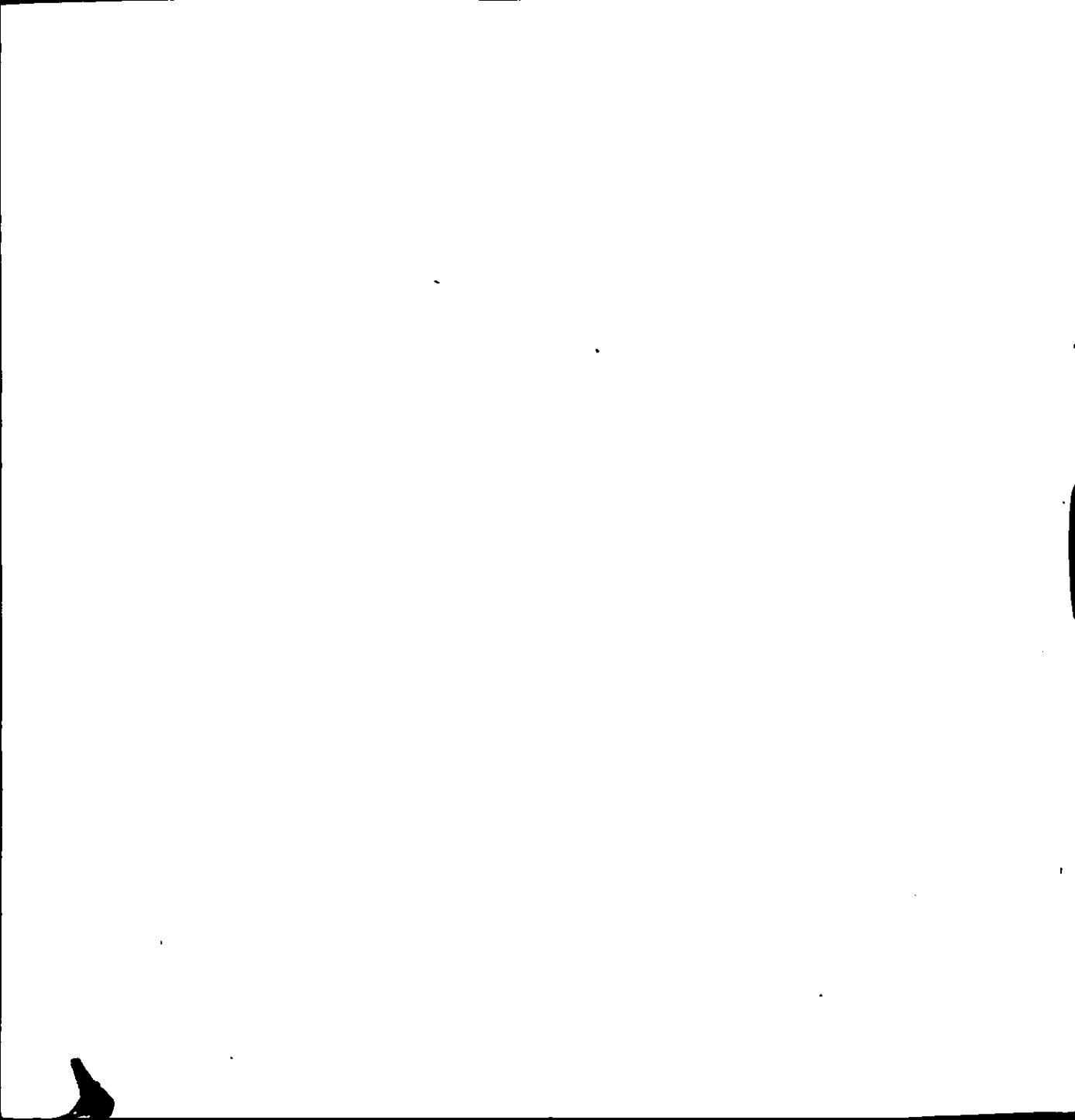
Aug 17 1930

## 20. UNDERTAKER

H.P. Smith

## ADDRESS

Ulrich Mo.



**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 Henry Registration District No. 347 File No. ....  
Township White Oak Primary Registration District No. 5495 Registered No. 62  
City ..... (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1860-5-13

7. AGE YEARS MONTHS DAYS  
40 3 3 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 8/20 1930 Dr. E. C. Peelor  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

17. I HEREBY CERTIFY That I attended deceased from .....  
....., 19....., 19.....  
that I last saw him ..... alive on ..... 19....., and that  
death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

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

**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

20. UNDERTAKER ADDRESS

19

S-26501