

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

Do not use this space.

NOV 24 1930

1. PLACE OF DEATH
County **Howell**
Township
City **Willow Springs, Mo.**

Registration District No. **385**
Primary Registration District No. **4228**

File No. **32742**
Registered No. **22**
St. _____ Ward)

2. FULL NAME **Mrs Sarah E. Richmond, Richmond**
(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 Female	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 Bert Richmond		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mch. 11th. 1870		
7. AGE	YEARS 60	MONTHS 6
	DAYS 28	If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **House wife**
(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) **Arkansas**

PARENTS	10. NAME OF FATHER George Dunbar
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ireland
	12. MAIDEN NAME OF MOTHER Dont know
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Dont know

14. INFORMANT **Bert Richmond**
(Address) **Willow Springs, Mo**

15. FILED **10/11, 1930**
J. B. Ferguson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Oct. 9th. 19 30**
17. I HEREBY CERTIFY, That I attended deceased from _____, 19 **30**, to **Oct 4, 19 30** and that I last saw him alive on **Oct 4, 19 30** and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Peritonitis
7 1/2 (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) **80** (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. **Same**

DID AN OPERATION PRECEDE DEATH? **No** DATE OF _____
WAS THERE AN AUTOPSY? **No**
WHAT TEST CONFIRMED DIAGNOSIS? **Microscopic of blood**
(Signed) **R. Kelley** M. D.

10/10, 1930 (Address) **Willow Springs 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 **City Cemetary**
DATE OF BURIAL **10/9 19 30**

20. UNDERTAKER **J. R. Burns**
ADDRESS **Willow Springs Mo**

WRITE 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.

