

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

Do not use this space.

36410

4820

**1. PLACE OF DEATH**

County Jackson  
Township Frank  
City Keosauqua (No. 1734)

Registration District No. 399  
Primary Registration District No. 1002

File No. 4820  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. 734 Duncan St., 9 Ward.

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**

Female

**4. COLOR OR RACE**

White

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

Widow

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

Peter M. Sanders

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

Apr 25 1847

**7. AGE**

YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>83</u>	<u>7</u>	<u>1</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work at home  
(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) Keosauqua

**10. NAME OF FATHER**

Wm

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

(STATE OR COUNTRY) no Record

**12. MAIDEN NAME OF MOTHER**

no Record

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

(STATE OR COUNTRY) no Record

**14. INFORMANT**

Mrs. Hall  
(Address) 734 Duncan

**15. FILED**

11-29-30 M. M. Crowe  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** Nov 26 1930

**17. I HEREBY CERTIFY, That I attended deceased from** Sept 21, 1930, to Nov 26, 1930; that I last saw him alive on Nov 26, 1930, and that death occurred, on the date stated above, at 5:30 p. m.

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

Chronic Myocarditis  
(duration) 2 yrs. mos. ds.

**CONTRIBUTORY (SECONDARY)** arterio-sclerosis  
(duration) 2 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? Clinical  
(Signed) James Middleton M. D.  
Nov 26, 1930 (Address) 4222 Westfall

\*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** Hampton Mo **DATE OF BURIAL** Nov 29 1930

**20. UNDERTAKER** Mrs. C. R. Foster **ADDRESS** R. C. Mo.

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.

424 2nd month of app  
via 1/18  
2-4