

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

Do not use this space.

40177
File No. 25
Registered No. 25

1. PLACE OF DEATH
 County Montgomery Registration District No. 595
 Township Upper Center Primary Registration District No. 4-353
 City Wellsville (No.) St. Ward

2. FULL NAME Sarah Artemesia Reighley
 (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 40 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*) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 28 - 1850

7. AGE 80 YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.

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) Missouri
 (STATE OR COUNTRY)

10. NAME OF FATHER Coly Parsons

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

12. MAIDEN NAME OF MOTHER Barry A. Parsons

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

14. INFORMANT Albert A. Reighley
 (Address) Wellsville, Mo.

15. FILED Dec 30 1930 ms. O. Pruitt
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 23 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 17
, 1930, to Dec 23, 1930
 that I last saw h. 21 alive on Dec 20, 1930 and that
 death occurred, on the date stated above, at 6 am m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Broncho Pneumonia
131
107#
 (duration) yrs. mos. 6 ds.

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

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) R. H. Stanford, M. D.
 , 19 (Address) Wellsville 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 Wellsville Mo **DATE OF BURIAL** Dec 26 1930

20. UNDERTAKER J. W. Keene **ADDRESS** Wellsville Mo

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.

JAN 21 1931

PARENTS

Certified

11-11-1964

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