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

Do not use this space.

41883

File No. .....

Registered No. 2 f

1. PLACE OF DEATH

County: Wright

Township: ~~Pleasant Valley~~

City: Mansfield (No. ..... St. ..... Ward)

Registration District No. 907

Primary Registration District No. 4548

2. FULL NAME: Nancy Jane Sikes.

(a) Residence. No. 90 years. St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 90 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Russell J. Sikes.

6. DATE OF BIRTH (MONTH, DAY AND YEAR): April 22-1831

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	99	8	7	

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN) Green Co. Indiana
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER: William Butler

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

12. MAIDEN NAME OF MOTHER: Elizabeth Wilson.

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

14. INFORMANT: Jas. K. P. Coday.
(Address) Mansfield Mo.

15. FILED 12/29, 1930. J. A. Fuson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Dec 29 1930

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 6. A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Smallpox

Did not see her time after death. 1/6/7

(duration) ..... yrs. 10 mos. ..... ds.

CONTRIBUTORY (SECONDARY): Information of age

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED (NOT AT PLACE OF DEATH)? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? Cottrell

(Signed) B. E. Latimer, M. D.

12-29, 1930 (Address) Harlowton 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: Mansfield Cem.

DATE OF BURIAL: 12/30/30

20. UNDERTAKER: Floyd A. Steffe

ADDRESS: Mansfield.

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.