

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

Do not use this space.

16965 ^a

1. PLACE OF DEATH

County North
Township Quincy
City Sturgeon (No.)

Registration District No. 904
Primary Registration District No. 6215

File No.
Registered No.
St. Ward)

2. FULL NAME

(a) Residence. No. St. Ward.
(Usual place of abode)
Length of residence in city or town where death occurred 37 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 25, 1873

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
57 4 19

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) Rockton
(STATE OR COUNTRY) Iowa

10. NAME OF FATHER Jacob Reed

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

12. MAIDEN NAME OF MOTHER Sarah A. Brown

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

14. INFORMANT Sherman R. Henneggin
(Address) Sturgeon Mo.

15. FILED March 29, 1932 Mrs. Lillian Boyd
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 17, 1931

17. I HEREBY CERTIFY, That I attended deceased from found patient dead, 19 31, that I last saw him alive on, 19 31, and that death occurred, on the date stated above, at 2 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Supposed to be Heart failure
death was instantaneous
200A (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 200W (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED at place of death
IF NOT AT PLACE OF DEATH, DATE OF

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS widow's witness (1)

(Signed) H. Spring, M. D.

, 19 (Address) Sturgeon

*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

Isadorah Cemetery 4/19 1931

20. UNDERTAKER ADDRESS

Arch C. Dunfee Grant City

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.

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