

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

Do not use this space.

13611

File No. \_\_\_\_\_  
Registered No. 308  
St. \_\_\_\_\_ Ward \_\_\_\_\_

1. PLACE OF DEATH  
89 County RANDOLPH Registration District No. 735  
Township \_\_\_\_\_ Primary Registration District No. 3034  
City MOBERLY (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME SALLIE DAMERON  
(a) Residence. No. 124 COLLINS St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred 4 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) WIDOW

5A. LE MARRIED, WIDOWED, OR DIVORCED HUSBANDS OF (OR) WIFE OF L. B. DAMERON

6. DATE OF BIRTH (MONTH, DAY AND YEAR) DEC. 25 - 1856

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>75</u>	<u>3</u>	<u>8</u>	

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) MISSOURI

10. NAME OF FATHER HENRY MILLER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) MISSOURI

12. MAIDEN NAME OF MOTHER DONT KNOW

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) DONT KNOW

14. INFORMANT MRS EFFIE HAYNES  
(Address) 124 COLLINS ST. MOBERLY MO.

15. FILED 4/4 19 32 Thos. S. Fleming REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 3 1932

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 1932, to April - 3 - 1932 that I last saw h. alive on April 3, 1932 and that death occurred, on the date stated above, at 9:15 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

influenza  
23A (duration) \_\_\_\_\_ yrs. mos. ds.  
11A (duration) \_\_\_\_\_ yrs. mos. ds.  
CONTRIBUTORY tuberculosis (SECONDARY) (duration) \_\_\_\_\_ 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? \_\_\_\_\_  
(Signed) [Signature] M. D.  
. 19 (Address) MOBERLY, 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 GRAND PRAIRIE CEM. DATE OF BURIAL APRIL 6 32

20. UNDERTAKER SNOW-LEAVERTON ADDRESS MOBERLY 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.

MAY 28 1932

PARENTS

MB



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Randolph  
Township  
City Moberly (No. \_\_\_\_\_)

Registration District No. 735  
Primary Registration District No. 3034

File No. \_\_\_\_\_  
Registered No. 308 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Jessie Dameron

(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**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 3, 1932

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

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

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

I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_  
11. Total time (years) spent in this occupation \_\_\_\_\_

Date of onset \_\_\_\_\_

Other contributory causes of importance:  
Tuberculosis Pulmonary

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

13. NAME  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

15. MAIDEN NAME  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT (ADDRESS)

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_

19. UNDERTAKER (ADDRESS)

(Signed) \_\_\_\_\_, M. D.

20. FILED 6/7 1932 Thos. S. Fleming Registrar.

**SUPPLEMENTARY 23**

REGISTRAR SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.  
No. B-1000 of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE should be written in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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