

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

Do not use this space.

15004

1. PLACE OF DEATH

County Shelby
Township Linton
City Linton (No. _____)

Registration District No. 830
Primary Registration District No. 6090

File No. 9
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 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) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 20 - 1868

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	63	10	3	25

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 _____

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

13. NAME Dr. B. Lister

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

15. MAIDEN NAME Louisa Sage

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT J. M. Byland (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE April 25 1932 (CITY) (DATE)

19. UNDERTAKER (ADDRESS) Blanchard Mo

20. FILED 5-10 1932 M. H. Byland Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 23, 1932

22. I HEREBY CERTIFY, That I attended deceased from April 19, 1932 to April 23, 1932
I last saw her alive on April 12, 1932. Death is said to have occurred on the date stated above, at 6-30am.
The principal cause of death and related causes of importance were as follows:

peralysis
87 D

Other contributory causes of importance: _____

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) A. J. Tals D. C. M. D.
(Address) Clarence 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.

102
31 1932

**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 Shelby
Township Lentendu
City (No.)

Registration District No. 830
Primary Registration District No. 609-1

File No.
Registered No. 9
St. Ward

2. FULL NAME

Sarah Ann Byland

(a) Residence, No. St. Ward.
(Usual place of abode)

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

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 23 1932

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

22. I HEREBY CERTIFY That I attended deceased from

I last saw h..... 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. ormin.

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

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.....

General Paralysis
Other contributory causes of importance: 8210

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

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

MOTHER FATHER 13. NAME

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

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

Manner of injury.....
Nature of injury.....

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

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

19. UNDERTAKER (ADDRESS)

20. FILED 5-10 1932 Madge Good Registrar

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

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