

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

Do not use this space.

35070

File No. _____
Registered No. 90 _____
St. _____ Ward) _____

1. PLACE OF DEATH

County Cedar Registration District No. 165
Township Lincoln Primary Registration District No. 6-2-31
City Stockton (No. _____) St. _____ Ward) _____

2. FULL NAME

Samuel Nathan York
(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

3. SEX Male 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 Mary York

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 30-1866

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
66 10 ✓

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Farming
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Bear Creek
(STATE OR COUNTRY) Cedar MI

10. NAME OF FATHER J.P. York

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

12. MAIDEN NAME OF MOTHER Sarah Ellen

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

14. INFORMANT Alma York
(Address) Nathan Stockton, Missouri

15. FILED Dec 1932 E. L. Smith
Mary Bayless REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 30 1932

17. I HEREBY CERTIFY, That I attended deceased from 11-27- 1932, to 11-30 1932 that I last saw human alive on 11-30 1932 and that death occurred, on the date stated above, at 1 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia following operation for ruptured gall bladder.
127H (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 127H (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) J. A. Sumrell, M. D.

11-30 1932 (Address) Stockton 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 DATE OF BURIAL

Stockton Cemetery Dec 1 1932

20. UNDERTAKER ADDRESS

W.C. Davis Co Stockton

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.

Please state
cause of rup-
-ture of Gall
Bladder,

Her, Sirree

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Cedar
Township Linn
City _____ (No. _____)

Registration District No. 165
Primary Registration District No. 5231

File No. _____
Registered No. 90
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 <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>M</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>_____</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>_____</u>		
7. AGE YEARS	MONTHS	DAYS
If LESS than 1 day, ... hrs. or min.		
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) <u>_____</u>		11. Total time (years) spent in this occupation <u>_____</u>

MOTHER / FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>_____</u>
	13. NAME <u>_____</u>
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>_____</u>
	15. MAIDEN NAME <u>_____</u>
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>_____</u>
	17. INFORMANT (ADDRESS) <u>_____</u>
18. BURIAL, CREMATION, OR REMOVAL <u>_____</u>	
PLACE <u>_____</u>	DATE <u>_____</u> 19 <u>_____</u>
19. UNDERTAKER (ADDRESS) <u>_____</u>	
20. FILED <u>_____</u> 19 <u>_____</u>	

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-30, 1933

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

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

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

Respiratory following
operation for ruptured
abdominal aorta
infections shuff.

Other contributory causes of importance: 12 M

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

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) _____, M. D.
(Address) _____

Registrar. _____

REGISTRARS SHALL BE UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

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.