

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

Do not use this space.

2076

1. PLACE OF DEATH

County Reelade Registration District No. 449
 Township Sebrun Primary Registration District No. 4267
 City Sebrun (No. _____) St. _____ Ward _____

2. FULL NAME

(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 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 Julia Turner

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 17 1865

7. AGE YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>67</u>	<u>5</u>	<u>5</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Merchant

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) Tenn

13. NAME Not known

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known

15. MAIDEN NAME Not known

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known

17. INFORMANT (ADDRESS) Julia Turner Sebrun Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Hartwell Meade DATE 1-23 1933

19. UNDERTAKER (ADDRESS) Rahway Sebrun

20. FILED Jan 23 1933 J. M. Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 22 1933

22. I HEREBY CERTIFY, That I attended deceased from Jan 17 1933, to Jan 22 1933
 Last saw him alive on Jan 21 1933. Death is said to have occurred on the date stated above, at 6:30 a.m.

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

Impacted stone in Gall Bladder
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Other contributory causes of importance: Cholelithiasis

Name of operation none Date of _____

What test confirmed diagnosis? none 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? no

If so, specify _____

(Signed) H. A. Hamilton, M. D.

(Address) Sebrun, 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.

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