

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.

SEP 14 1934

# MISSOURI STATE BOARD OF HEALTH

## BUREAU OF VITAL STATISTICS

### CERTIFICATE OF DEATH

Do not use this space.

29896

## 1. PLACE OF DEATH

County *Lafayette*Registration District No. *464*

Township

Primary Registration District No. *4277*

City

(No)

St.

Ward)

## 2. FULL NAME

(a) Residence, No.

(Usual place of abode)

St.

Ward.

(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

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

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

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, .....hrs. or .....min.

OCCUPATION

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)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE

DATE

19. UNDERTAKER (ADDRESS)

20. FILED

Sept 8 - 1934

Mrs. E. M. Erdman Registrar

## 3 MEDICAL CERTIFICATE OF DEATH

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

8-15-1934

22. I HEREBY CERTIFY, That I attended deceased from

10-4-1933, to 8-15-1934

I last saw him alive on 8-14-1934. Death is said

to have occurred on the date stated above, at 12:45 p.m.

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

Date of onset

Pneumonia, hypersthenic

Other contributory causes of importance:

Myocarditis, Apoplexy

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

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

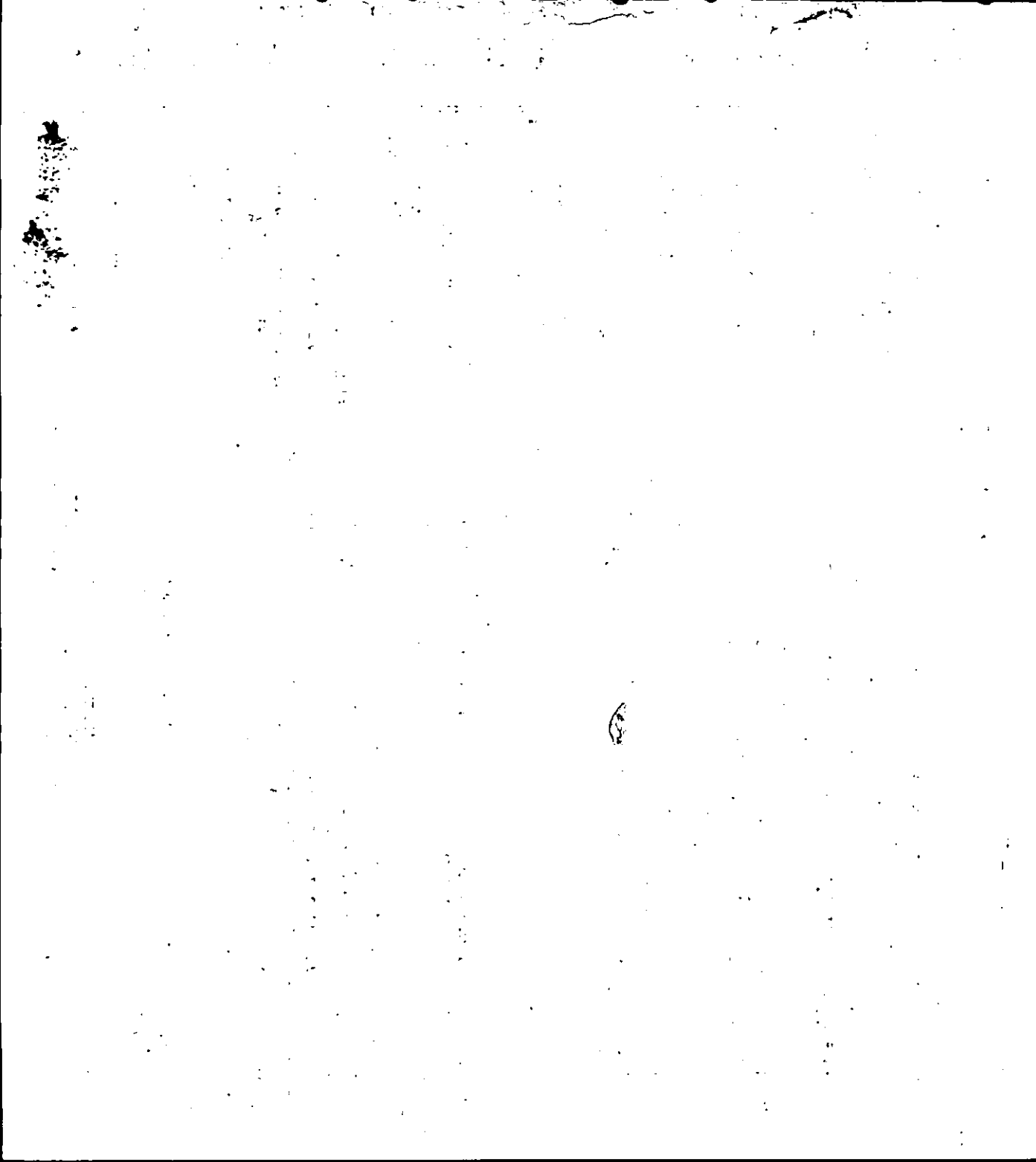
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) E. B. M. M. M., M. D.

(Address) Edessa, Mo.



#2 Lafayette

## DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

WASHINGTON

E. T. McLaugh, M. D.,  
Special Agent,  
Jefferson City, Mo.

82

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Sarah E. Baker  
Who died at \_\_\_\_\_ on 8-15-1934  
Residence: No. \_\_\_\_\_ St. \_\_\_\_\_

(If nonresident, city or town)

Length of residence in city or town where death occurred: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Sex F Color or race W Single    married    widowed or divorced   

Date of birth \_\_\_\_\_ Age: Years 89 Months 1 Days 1

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month \_\_\_\_\_ Year \_\_\_\_\_

Birthplace (State or country) \_\_\_\_\_

Birthplace of father (State or country) Pneumonia, Hypertatic

Birthplace of mother (State or country)   

Principal cause of death: neither lobar or chronic - Broncho

Other contributory causes of importance myocarditis

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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 \_\_\_\_\_

Was disease or injury in any way related to occupation of deceased? 93d1

If so, specify \_\_\_\_\_

Name of physician \_\_\_\_\_

Address of physician \_\_\_\_\_

(Signature of Registrar Mrs E. M. Goodwin) Date filed \_\_\_\_\_

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 404

Very truly yours,

Primary Reg. Dist. No. 4277E. T. McLaugh  
State Registrar  
Special Agent.

5-29896