

OCT 12 1934

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

Do not use this space.

Dr. Mc...
33689
File No. 231
Registered No. 668
St. ... Ward

80
4
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1. PLACE OF DEATH *Pettus*
County.....*Pettus* Registration District No. *668*
Township..... Primary Registration District No. *3032*
City.....*Seelyville* (No. *Bathwell Hosp.*)
2. FULL NAME *Roberta May Selvey*
(a) Residence, No. *Adelia Route 2* 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) *single*
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Jan 10 - 1917*
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
17 *8* *14*

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *at school*
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) *Deepwater, Mo.*
13. NAME *Bert Selvey*
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Henry County, Missouri*
15. MAIDEN NAME *Allie Saberslock*
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Deepwater, Mo.*

17. INFORMANT (ADDRESS) *Bert Selvey, Adelia Route 2*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Crown Hill* DATE *9-26-34*

19. UNDERTAKER (ADDRESS) *McDaughtin Bros, Seelyville*

20. FILED *9-25-34* 1934 *Flora Slack* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept 24, 1934*
22. I HEREBY CERTIFY, That I attended deceased from *Sept 24, 1934*
I last saw *her* alive on *Sept 24, 1934* Death is said to have occurred on the date stated above, at *11* m.
The principal cause of death and related causes of importance were as follows:

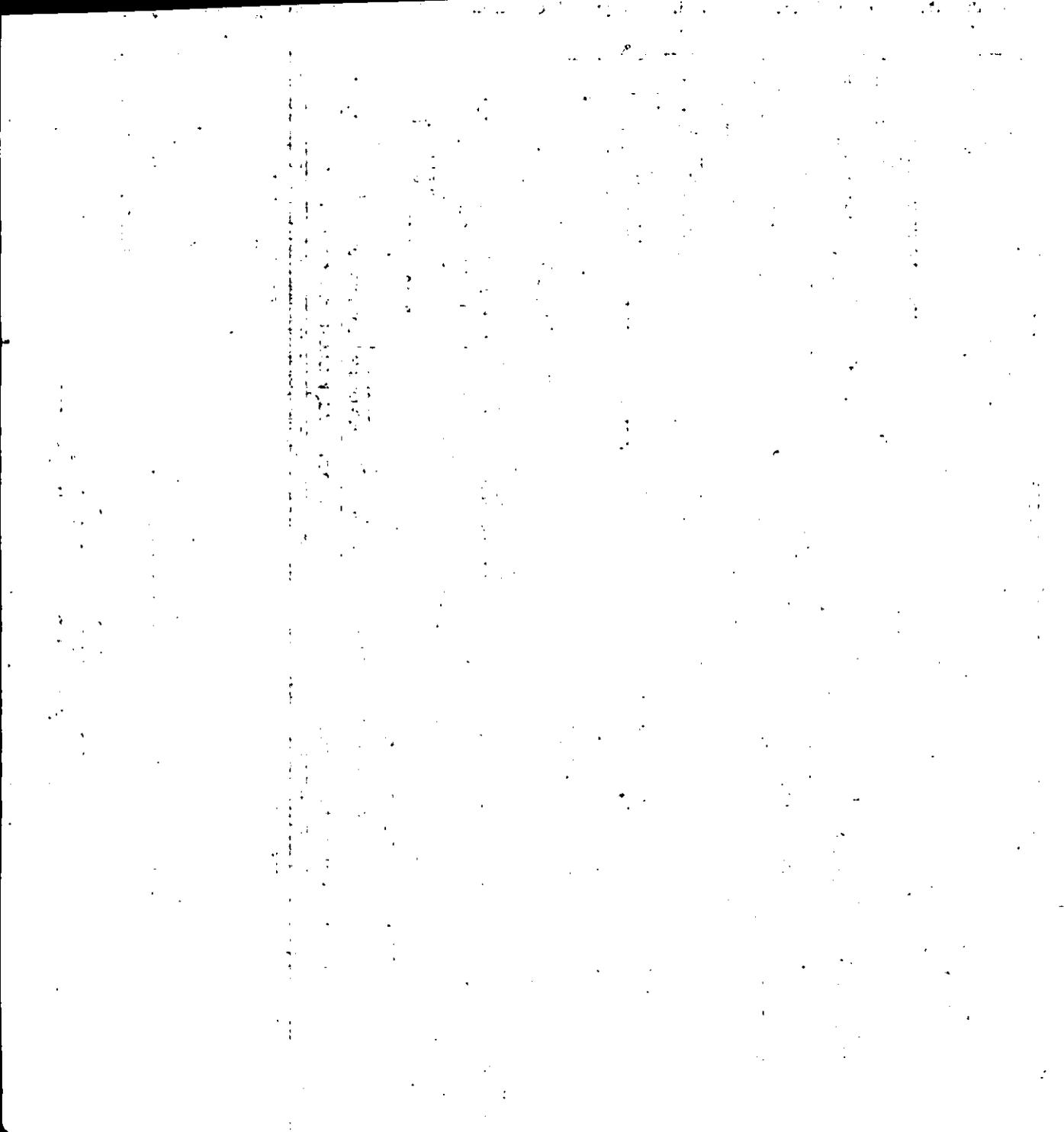
Date of onset *139B*
139C
Other contributory causes of importance: *129*
139B
139C
129
Name of operation *Peritonectomy* Date of *Sept 23*
What test confirmed diagnosis? Was there an autopsy?

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? *no*
If so, specify
(Signed) *J. E. ...* M. D.
(Address) *...*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION, if any.



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Pettis Registration District No. 668
Township Sedalia Primary Registration District No. 3032
City Sedalia (No. _____) St. _____ Ward _____

File No. 331
Registered No. _____

2. FULL NAME

Roberta May Selvey
(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan-10-1917
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
17 8 14

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 1917 Jean Slack Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept-24-1934

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____. Death is said to have occurred on the _____ stated above, at _____ m.

The principal cause of death and related causes of importance were as follows: Perforating tube operation Date of onset _____

Other contributor causes of importance: No knowledge of gross abdominal ulcers - not surgical case

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) _____

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED

FEB 7 1996

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