

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!

APR 7 1935

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

Do not use this space.

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1. PLACE OF DEATH

County Franklin Registration District No. 295
Township Wasson Primary Registration District No. 4179
City Sullivan (No. _____) St. _____ Ward _____

2. FULL NAME

(a) Residence, No. Sullivan 200 Ward. _____
(Usual place of abode) _____ (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 1 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) infant

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 23, 1934

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
1 1 1

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. infant
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) Sullivan, Mo.

13. NAME Daniel Long

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pauli Valley, Oklahoma

15. MAIDEN NAME Mabel Kaye

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

17. INFORMANT (ADDRESS) Daniel Long, Sullivan, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Buffalo, Mo. DATE March 26, 1935

19. UNDERTAKER (ADDRESS) Wm. P. Shaffer, Sullivan, Mo.

20. FILED 776 25 Abstracts Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 24, 1935

22. I HEREBY CERTIFY, That I attended deceased from 3-20-1935 to 3-24-1935

I last saw him alive on 3-24-1935 Death is said to have occurred on the date stated above, at 10:45 a.m.

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

Pneumonia (Bacterial) / 3/18/35

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? Culture 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.

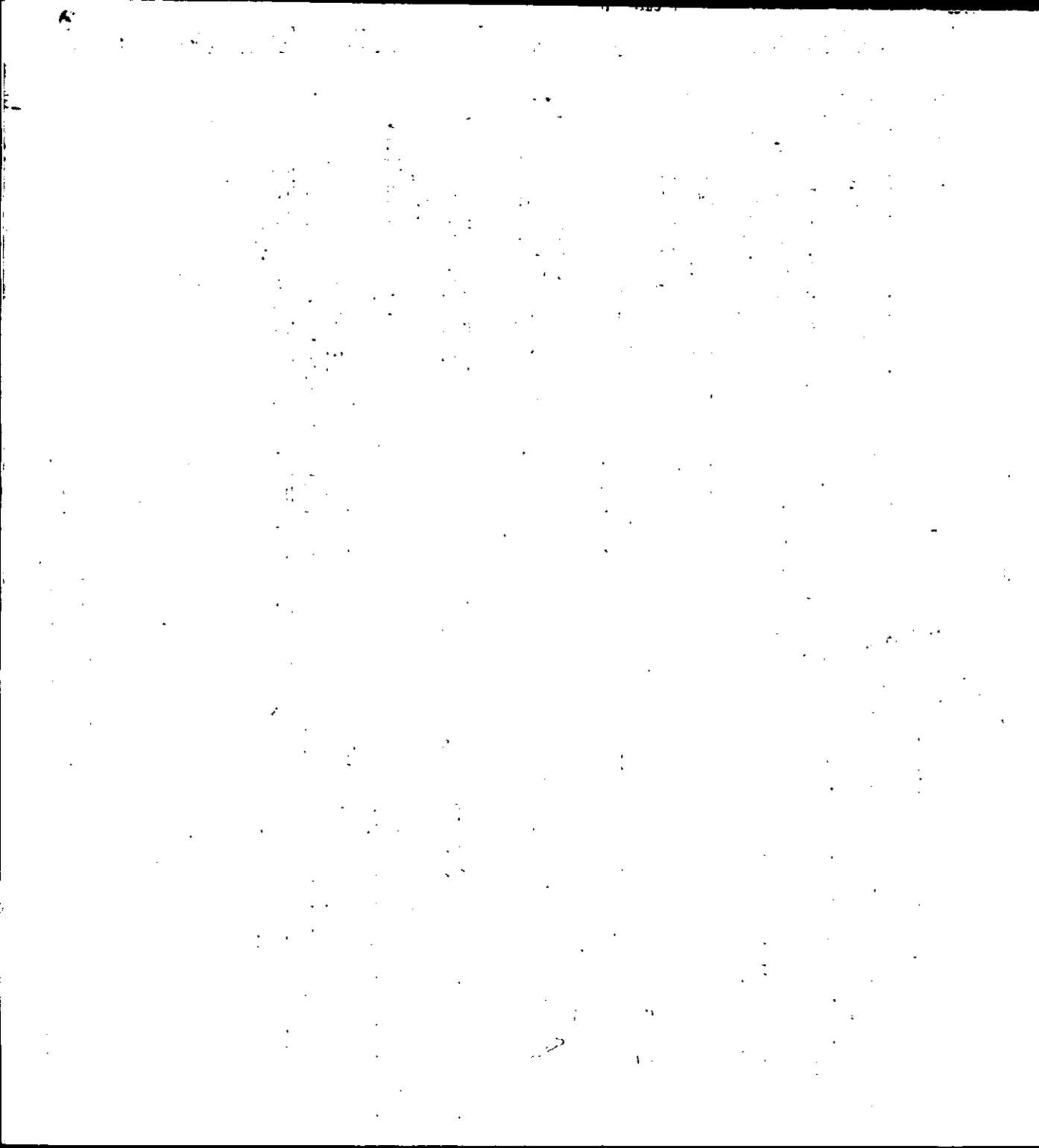
Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify _____ (Signed) Wm. P. Shaffer, M. D.

(Address) Sullivan, Mo.



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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County Franklin
Township.....
City..... (No.....)

Registration District No. 295
Primary Registration District No. 4179

File No.....
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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S

5A. 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)

FATHER 13. NAME

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

MOTHER 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 5718 30 October Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 24, 1935

22. I HEREBY CERTIFY, That I attended deceased from, 19....., 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:

Bronchial pneumonia

Date of onset

Other contributory causes of importance:

followed acute cold

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).....

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important.

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