

JAN 21 1935

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

Do not use this space.

10331-2  
255

1. PLACE OF DEATH

County *St. Francois*  
Township *St. Francois*  
City *Clays*

Registration District No. *772*  
Primary Registration District No. *463*

File No. *255*  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

*James F. Sutterfield*

(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. *6* 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) *Widowed*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Martha Sutterfield*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Apr. 10-1854*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
*80 11 16*

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) *Reynolds County*  
(STATE OR COUNTRY) *Missouri*

PARENTS

10. NAME OF FATHER *Jacob Sutterfield*  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Reynolds Co*  
(STATE OR COUNTRY) *Missouri*  
12. MAIDEN NAME OF MOTHER *Elyzabet West*  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Commerce*  
(STATE OR COUNTRY) *Missouri*

14. INFORMANT *Mrs. Grace Hamm*  
(Address) *Clays Mo*

15. *12/27*, 1935 *J. F. Barrett*  
REGISTRAR *JFD*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Mich. 26* 19*35*

17. I HEREBY CERTIFY, That I attended deceased from *Nov. 1st*, 19*35*, to *Mich. 26*, 19*35*, that I last saw him alive on *Mich. 24*, 19*35*, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Mitral Insufficiency*

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? *no* DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Thyroid Exam*  
(Signed) *F. W. Gable*, M. D.

*3/26*, 19*35* (Address) *Bismarck 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

*Bismarck Mo.*

*3-27-1935*

20. UNDERTAKER

ADDRESS

*White Oak Hill*

*Bismarck 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.

