MAY 27 1936

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

16671

1. PLACE OF DEATH
County St. Francois — Registration District No. 774 — File No. 300
Township St Francois — Primary Registration District No. 4465 — Registered No.
City Flat River (No. ..... St. ..... Ward)

2. FULL NAME William Sales
(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): Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Mary Sales

6. DATE OF BIRTH (MONTH, DAY AND YEAR): May 10th 1842

7. AGE: YEARS 94 — MONTHS 0 — DAYS 5 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd Jobs
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Kentucky

PARENTS
10. NAME OF FATHER: John Sales
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown

14. INFORMANT: Clara Burnia
(Address) Flat River Mo

15. FILED 4/27 1936 C B Farrar REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): April 15 1936

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1936, to April 15, 1936 that I last saw h. 1 m alive on April 13, 1936 and that death occurred, on the date stated above, at 8 20 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chr Myocarditis
93
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Senility
(duration) ..... yrs. ..... mos. ..... ds.

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? Exam
(Signed) C H Appleberry, M. D
, 19 (Address) Flat River 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Mine Lamotte Cemetery — DATE OF BURIAL: 4-16 1936

20. UNDERTAKER: Caldwell Bros — ADDRESS: Flat River 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.

Ocla Hallbrooks.