

OCT 21 1936

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

Do not use this space.
34200
File No. _____
Registered No. 830
St. _____ Ward _____

1. PLACE OF DEATH

County St. Louis Registration District No. 1021
Township _____ Primary Registration District No. 2001
(No. 1021 St. Louis)

2. FULL NAME

(a) Residence, No. 1021 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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Anna M. Sibley

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 22 - 1870

7. AGE YEARS 66 MONTHS 2 DAYS 28 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as spinning, sawyer, bookkeeper, etc. Lawyer

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) Iowa

13. NAME John

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lawrence, Mo.

15. MAIDEN NAME _____

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

17. INFORMANT (ADDRESS) James M. Sibley

18. BURIAL, CREMATION, OR REMOVAL PLACE Springfield, Mo. DATE 10/29/36

19. UNDERTAKER (ADDRESS) Springfield, Mo.

20. FILED 10-1-1936 Dr. Chas. A. George Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/30/36

22. I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1936 to 9/30, 1936

I last saw her alive on 9/20, 1936. Death is said to have occurred on the date stated above, at 1:00 p. m.

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

Angina pectoris Date of onset 1934

MI

Other contributory causes of importance: _____

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 _____, 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? _____

(Signed) J. B. Johnson

(Address) _____, M. D.

SPRINGFIELD, 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.

