

DEC'D FEB 25 1939

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

3453
Do not use this space.

1. PLACE OF DEATH

(a) County Pettis Registration District No. 668
(b) Township _____ Primary Registration District No. 3032
(c) City Sedalia (d) Street No. 423 So. New York St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

4071 Milton Calvin Fall
(a) Residence, No. 423 So. New York St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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 Florence Fall

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 4, 1855

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
83 5 11

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Unemployed
9. Industry or business in which work was done, as 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) Ind.

FATHER 13. NAME John Fall

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

MOTHER 15. MAIDEN NAME Nancy Aldridge

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

17. INFORMANT (ADDRESS) L.B. Fall
Beaman, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Olive Branch DATE Jan. 17, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Gillespie Funeral Home
Sedalia, Mo.

20. FILED Jan 16, 1939 Mrs Harry Sueda
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 15 1939, 19

22. I HEREBY CERTIFY. That I attended deceased from 1-8, 1939, to 1-14, 1939
I last saw him alive on 1-14, 1939 Death is said to have occurred on the date stated above, at 8:30 a. m.

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

Cerebral Hemorrhage Date of onset 1-6-39

Other contributory causes of importance:

arterio Sclerosis

Name of operation none Date of _____
What test confirmed diagnosis? clinical 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) Alfred S. Mowbray, M. D.
111 W 4 Sedalia Mo (Address)

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.

Received
District Health Officer No. 8,
District File Number
2/8/39
to Filed

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, _____
or by _____

Registered Apprentice No. _____, working under my personal supervision

Signed L. E. Boulton

Licensed Embalmer No. 3867

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.