

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

29940  
 Do not use this space.

REC'D SEP 19 1939

1. PLACE OF DEATH <sup>2</sup>  
 (a) County Phelps Registration District No. 677  
 (b) Township Raele Primary Registration District No. 4403 Registered No. 96  
 (c) City Raele (d) Street No. \_\_\_\_\_ 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 <sup>513</sup> Sallie Van Patten  
 (a) Residence, No. Raele Route 1 St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX ♀ 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John B. Van Patten

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 16, 1872

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>66</u>	<u>9</u>	<u>10</u>	

OCCUPATION

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

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) Lewis Co Mo

FATHER

13. NAME O. V. Adams

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lewis Co Mo

MOTHER

15. MAIDEN NAME Mary Bathel

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lewis Co Mo

17. INFORMANT (ADDRESS) J. B. Van Patten

18. BURIAL, CREMATION, OR REMOVAL PLACE Raele DATE Aug 28, 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. Lee Adams  
R. Lee Adams  
Mo

20. FILED Aug 28, 1939 Joe. F. Ayers  
 Loc. Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 26, 1939

22. I HEREBY CERTIFY, That I attended deceased from June 1939, to Aug 28, 1939  
 last saw h. s. alive on Aug 25, 1939. Death is said to have occurred on the date stated above, at 8 p. m.  
 The principal cause of death and related causes of importance were as follows:  
Aortic stenosis

Date of onset 1937

Other contributory causes of importance: acute nephritis 7/15/39

Name of operation \_\_\_\_\_ 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) W. Lee Adams M. D.  
C. B. Adams (Address) St. James, 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.

92A

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.

RECEIVED

District Health Officer No. 5, :

District File Number 939 223

Date Filed 9-13-39

Signed S. B. Jones

Licensed Embalmer No. 3394

P. O. Address Rolla Mo

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.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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(a) County Phelps Registration District No. 677  
(b) Township..... Primary Registration District No. 4403 Registered No. 96  
(c) City Palla (d) Street No..... (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 Sallie Sawpatten  
(a) Residence, No. .... 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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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.  
66 9 10

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
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)

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. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-26, 1939

22. I HEREBY CERTIFY, That I attended deceased from

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:

acute stenosis Date of onset

131

Other contributory causes of importance:

acute nephritis

Chr. nephritis

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) Wm H Brewer, M. D.

(Address) St James mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

WILLIAM H. BREUER, M. D.  
PHONE RES. 19

EAMILA STRICKER, M. D.  
PHONE RES. 188

DRS. BREUER AND STRICKER

OFFICE HOURS:

ST. JAMES - 8 TO 12 A. M. AND 1 TO 4 P. M. - PHONE 28  
ROLLA HOSPITAL - 10 TO 12 A. M. AND 2 TO 4 P. M. PHONE 68  
AND BY APPOINTMENT  
ST. JAMES, MISSOURI

October 10, 1939.

*P. Kester*

Dr. Harry F. Parker,  
Special Agt.,  
Bureau of the Census.,  
Jefferson City, Mo.

This certificate is incorrect.  
The principal cause of death  
~~should~~ should be Chronic Nephritis.  
Contributory cause: Aortic stenosis.

Yours very truly,

*William H. Breuer*

WHP.nh

William H. Breuer, M.D.