DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22592

Registration District No. Primary Registration District No. 725 Registrar's No. 4431

1. PLACE OF DEATH:
(a) County Ralls
(b) City or town Center
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community 50 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Ralls
(c) City or town Center
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Myrtle M. Sperry
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex Female
5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife O. A. Sperry
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased May 16 1881 (Month) (Day) (Year)
8. AGE: Years 58 Months 11 Days If less than one day hr. min.
9. Birthplace Ralls Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation Housewife
11. Industry or business Own Home
FATHER 12. Name [illegible]
13. Birthplace Center (City, town, or county) Mo (State or foreign country)
MOTHER 14. Maiden name Elizabeth [illegible]
15. Birthplace Pike Co (City, town, or county) Mo (State or foreign country)
16. (a) Informant's own signature [illegible] Long
(b) Address Center Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/40 (Month) (Day) (Year)
(c) Place: burial or cremation Center
18. (a) Signature of funeral director [illegible]
(b) Address Center
19. (a) 4/18/40 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 16 year 1940 hour 7 minute 45 P. M.
21. I hereby certify that I attended the deceased from Feb 22, 1940 to April 16, 1940
that I last saw her alive on April 16, 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma of Stomach-Liver-	6 mo.
Due to unknown Bladder	
Due to unknown	
Other conditions none (Include pregnancy within 3 months of death)	
Major findings: Of operations none	
Of autopsy none	

PHYSICIAN: Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature E. H. Brooks (M. D. or other) Do.
Address Center, Mo. Date signed 4-18-40

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.

(Licensed Embalmer's Statement on Reverse Side)

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RECEIVED
District Health Officer No. 10
District File Number 7-40-1423
Date Filed JUL 12 1940

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 [signature]

Licensed Embalmer No. 3356

P. O. Address ....

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

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

o. 2B
-21-40
X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 225 92

Registration District No. 725 Primary Registration District No. 4431 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Ralls
(b) City or town Center (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Myrtle M. Sperry
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years 58 Months 11 Days If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 16 year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma Stomach liver bladder — Duration 2 [illegible]
Due to primary site according to first [illegible] and ninth (9) [illegible] on the left side.
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations 53
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature C. H. Brooks (M. D. or other)
Address Center, Mo. Date signed