WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

PLACE OF DEATH

County Pettis

Township ______ or Village ______ or City Sedalia Mo (NO. ______ St.; ______ Ward)

Registration District No. 668 File No. 37063

Primary Registration District No. 8032 Registered No. 283

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Cora May Anderson

PERSONAL AND STATISTICAL PARTICULARS

SEX F

COLOR OR RACE W

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Married

DATE OF BIRTH Feb (Month) 18 (Day), 1891 (Year)

AGE 22 yrs. 8 mos. ______ ds. If LESS than 1 day, ______ hrs. or ______ min.?

OCCUPATION (a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) ——

BIRTHPLACE (City or town, State or foreign country) Mo

PARENTS

NAME OF FATHER J. S. K. Miller

BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo

MAIDEN NAME OF MOTHER Mollie Kelly

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. F. Anderson

(ADDRESS) 1403 E 4 Sedalia

Filed Nov 25 1913 A. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov (Month) 25 (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from October 5, 1913, to Nov. 25, 1913, that I last saw her alive on Nov. 25, 1913, and that death occurred, on the date stated above, at 6:45 p.m.

The CAUSE OF DEATH* was as follows:

General Peritonitis

138

129

(Duration) ______ yrs. ______ mos. 3 ds.

Contributory (SECONDARY) Pyo-Salpinx with operation

(Duration) ______ yrs. 2 mos. —— ds.

(Signed) Chas. [illegible] M. D.

Nov 25, 1913 (Address) Sedalia Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ______ yrs. ______ mos. ______ ds. In the State ______ yrs. ______ mos. ______ ds.

Where was disease contracted if not at place of death? ______

Former or usual residence ______

PLACE OF BURIAL OR REMOVAL LaDue Mo

DATE OF BURIAL ——, 191__

UNDERTAKER Sedalia Undertaking Co

ADDRESS Sedalia Mo

Revised United States Standard Certificate of Death

MISSOURI STATE BOARD OF
BUREAU OF VITAL STATISTI
CERTIFICATE OF DEATH

(Census and American Public Health

PLACE OF DEATH

County..........

Township .... Registration District No.......... File No..........
or
Village.......... Primary Registration District No.......... Registered No..........
or
City ....(NO.........., ...St.;..........Ward) [If d hospit give of str

FULL NAME..........

PERSONAL AND STATISTICAL PARTICULARS		
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)
DATE OF BIRTH .... (Month) (Day) , 1 (Year)		
AGE ....yrs..........mos..........ds.	If LESS than 1 day, ...hrs. or ......min.?	
OCCUPATION (a) Trade, profession, or particular kind of work .... (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country)		
PARENTS	NAME OF FATHER	
	BIRTHPLACE OF FATHER (City or town, State or foreign country)	
	MAIDEN NAME OF MOTHER	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country)	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)..........

(ADDRESS)..........

Filed ...., 191......, ... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH .... (Month)

I HEREBY CERTIFY, that I attended ...., 191......, to ....

that I last saw h......alive on ....

and that death occurred, on the date stated abo

The CAUSE OF DEATH* was as follows:

....

..........(Duration)..........yrs..........

Contributory.......... (SECONDARY)

..........(Duration)..........yrs..........

(Signed)..........

.........., 191...... (Address)..........

*State the Disease Causing Death, or, in deaths from (1) Means of Injury; and (2) whether Accidental, Suicidal, or H

LENGTH OF RESIDENCE (For Hospitals, Institutio Recent Residents)

At place of death......yrs......mos......ds. In the State......yrs..

Where was disease contracted if not at place of death? ....

Former or usual residence..........

PLACE OF BURIAL OR REMOVAL	DATE
UNDERTAKER	ADDI