

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

Do not use this space.

22400

27 1929

**1. PLACE OF DEATH**

County St. Charles  
Township Cass  
City \_\_\_\_\_ (No. \_\_\_\_\_) \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 759  
Primary Registration District No. 6000

File No. \_\_\_\_\_  
Registered No. 5

**2. FULL NAME** Sarah Matilda Painter

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward. \_\_\_\_\_  
(Usual place of abode)

Length of residence in city or town where death occurred Mar of life yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Henry C. Painter

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7-7-11-17

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min. 17 yrs 11 mos 17 ds

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work St House  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) St Charles Co Mo  
(STATE OR COUNTRY)

10. NAME OF FATHER James A. Webb

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Warren Co Mo  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Sarah A. Freney

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Virginia  
(STATE OR COUNTRY)

14. INFORMANT Mrs Fingold (Sister)  
(Address) Fossil Mo

15. FILED 7-1-1929 O. A. Mulum REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-30-1929

17. I HEREBY CERTIFY, That I attended deceased from June 3, 1929, to June 30, 1929, that I last saw him alive on June 30, 1929, and that death occurred, on the date stated above, at 2:45 P.M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Endocarditis  
92B  
57B

CONTRIBUTORY (SECONDARY) Rheumatism  
(duration) 2 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

8 DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_

(Signed) Russ Miller, M. D.

7-1-1929 (Address) Fossil Mo

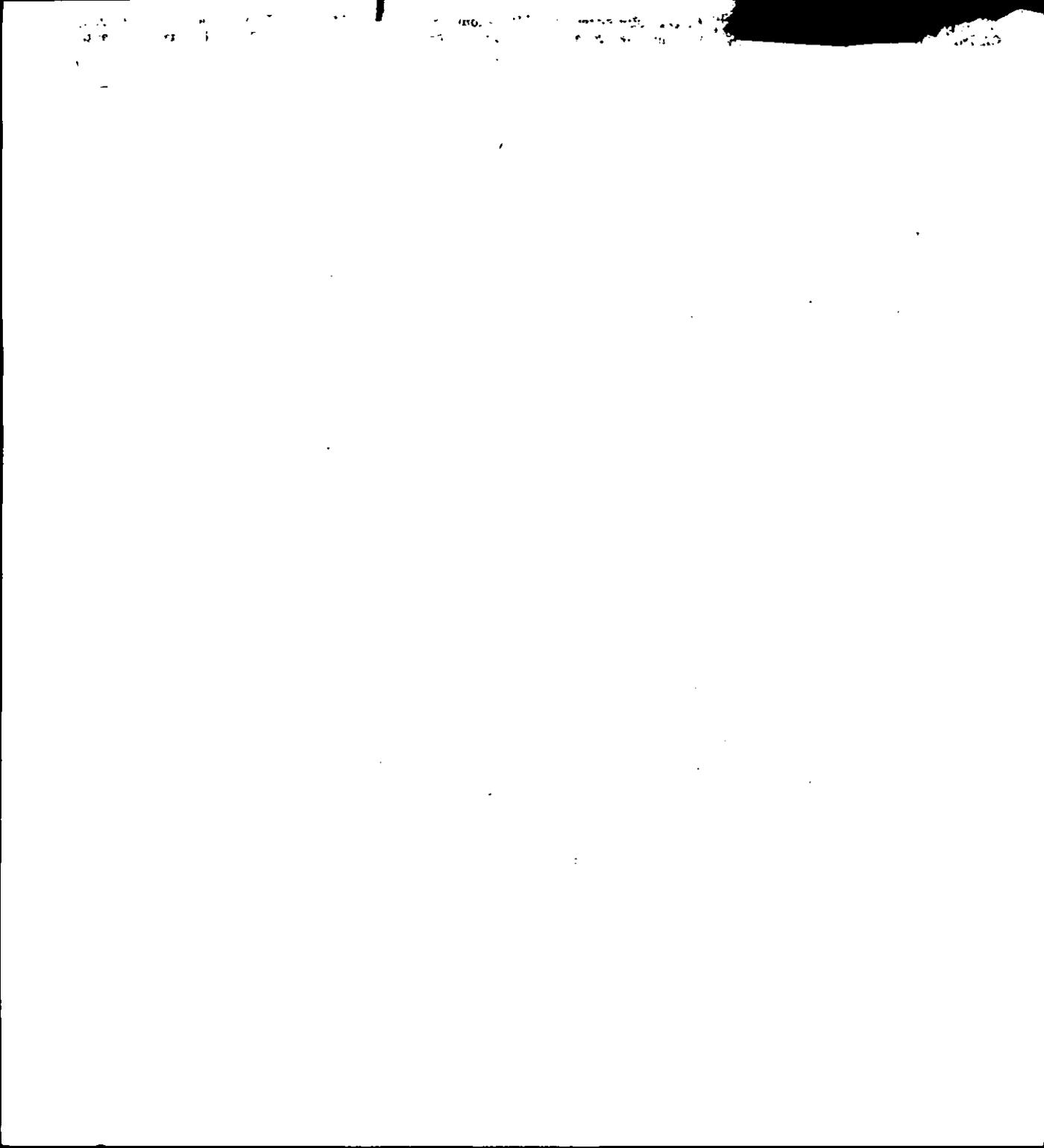
\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

Hickory Grove Cemetery 7-2-1929

20. UNDERTAKER T. C. Starnes ADDRESS Monticello Mo

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state 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**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County St. Charles Registration District No. 759 File No. \_\_\_\_\_  
 Township Callaway Primary Registration District No. 6080 Registered No. 8  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Sarah Matilda Painter

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident, give city or town and State)  
 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 13 - 1857

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>77</u>	<u>11</u>	<u>17</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work \_\_\_\_\_  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

PARENTS	10. NAME OF FATHER _____
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____
	12. MAIDEN NAME OF MOTHER _____
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

14. INFORMANT \_\_\_\_\_  
 (Address) \_\_\_\_\_

15. FILED Aug 10 19 29 D. H. Muller  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-30 1929

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_  
 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_  
 that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that  
 death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

\_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

, 19 \_\_\_\_\_ (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state. CAUSE OF DEATH in full terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-22400