

NOV 26 1930

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

Do not use this space.

33401

1. PLACE OF DEATH

County

Township

City

Lafayette
Lexington
Lexington

Registration District No.

Primary Registration District No.

461
3024

File No.

Registered No.

St.

Ward

90.

2. FULL NAME

(a) Residence No.

(Usual place of abode)

St.

Ward

(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

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

Rena Page Sawyer

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

Feb 10, 1853

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, hrs.
or min.

77

8

20

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work

Retired Farmer

(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)

Lexington, Mo.

10. NAME OF FATHER

Samuel L. Sawyer

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Nassau
New Hampshire

12. MAIDEN NAME OF MOTHER

Mary Ballaway

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Leitchburg
Vt.

14.

INFORMANT

(Address)

H. M. Peck
Oklahoma City, Okla.

15.

FILED

OCT 31 1930

G. W. Trudendall

REGISTRAR

4 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Oct 30 1930

17.

I HEREBY CERTIFY, That I attended deceased from
Oct 21, 1930, to Oct 30, 1930
that I last saw him alive on Oct 30, 1930, and that
death occurred, on the date stated above, at 2:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral
Thrombosis ten hours
proceeds hip 9 days.

CONTRIBUTORY

(SECONDARY)

Cerebral 1930
(duration) 2 yrs. 1940 mos. ds.

18. WHERE WAS DISEASE CONTRACTED

1030

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

A. J. Chalkley, M. D.

(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

Independence Mo

11/60/1930

20. UNDERTAKER

ADDRESS

Ernest Tegert

Lexington 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.

**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 Lafayette Registration District No. 461 File No. _____
 Township _____ Primary Registration District No. 3024 Registered No. _____
 City Lexington (No. _____) St. _____ Ward _____

2. FULL NAME

Thomas C. Sawyer
 (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M (write the word)

5A. W 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.

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)

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 _____ 19 _____ J. W. Anderson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 30 19 30

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Protruding fracture hip from fall
 (duration) yrs. mos. ds. 9

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE _____

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 plain 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

5-33401