

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

Do not use this space.

B. C. ...
35302

1. PLACE OF DEATH

County *Pettis*
Township *Sedalia*
City *Sedalia* (No. *Bothwell Hospital*)

Registration District No. *668*
Primary Registration District No. *3032*

File No. *35302*
Registered No. *294*
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ St., _____ Ward _____
(Usual place of abode)
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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 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 _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Sept 29 - 1898*

7. AGE YEARS *33* MONTHS *01* DAYS *19* If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as splanner, sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as silk mill, 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) *Kansas*

13. NAME *H. H. Robinson*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

15. MAIDEN NAME *Anna Belle McLeod*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ind.*

17. INFORMANT *H. H. Robinson* (ADDRESS) *Sedalia Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Sedalia Mo* DATE *Oct 26* 19*31*

19. UNDERTAKER *Silliman* (ADDRESS) _____

20. FILED *10-20* 19*31* *J. L. ...* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Oct 18* 19*31*

22. I HEREBY CERTIFY, That I attended deceased from *May 31* 19*31*, to *Oct 18* 19*31*. I last saw her alive on *Oct 18* 19*31*. Death is said to have occurred on the date stated above, at *29* m.

The principal cause of death and related causes of importance were as follows: *Post Partum Haemorrhage* Date of onset *Oct 16*

Other contributory causes of importance: *11/4/31*

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ 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. S. ...* M. D.

(Address) *Sedalia Mo*

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.

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