V. S. No. 2.

MARGIN RESERVED FOR BINDING

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.

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

18642

PLACE OF DEATH

County Scott — Registration District No. 821 — File No. 43

Township Richland — Primary Registration District No. 6670 — Registered No.

City Sikeston Mo (No. ..... St. ..... Ward)

FULL NAME Salathiel S. Cashdollar

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

th of residence in city or town where death occurred 3 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
le	white	Married

F MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Martha Cashdollar

ATE OF BIRTH (MONTH, DAY AND YEAR) Apr. 28—1859

GE 74 YEARS	MONTHS	12 DAYS	If LESS than 1 day, ... hrs. or ..... min.

CCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Premis to strake Michael Jenn

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

(c) Name of employer Self

IRTHPLACE (CITY OR TOWN) Sparta Tenn.
(STATE OR COUNTRY)

0. NAME OF FATHER Unknown

1. BIRTHPLACE OF FATHER (CITY OR TOWN) —
(STATE OR COUNTRY) no history

2. MAIDEN NAME OF MOTHER

3. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

INFORMANT C. A. Bradshaw
(Address) Sikeston Mo

FILED 6/10, 1935 Walter E. Jenn
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 10 1935

17. I HEREBY CERTIFY, That I attended deceased from Aug Jan 1 1932, to May 10 1935 that I last saw him alive on May 10 1935, and that death occurred, on the date stated above, at 8 to 9 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
82 A 8 2 A
(duration) yrs. mos. 4 ds.

CONTRIBUTORY (SECONDARY) Suffered first attack about 5 yrs ago (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) A. A. Mayfield, M. D.

May 11, 1935 (Address) Sikeston 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Campbell Mo. Woodlawn Cem.	May 12 1935

20. UNDERTAKER	ADDRESS
E. W. Landers	Campbell Mo.

V. S. No. 2.

MARGIN RESERVED FOR BINDING

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....Wa

2. FULL NAME .....

(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF 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)

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....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)

.....(duration)..... ...yrs. .....mos.

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).....,

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, s
(1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL,
HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIA

20. UNDERTAKER | ADDRESS