

DEC 20 1937

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

Do not use this space.

41579

1. PLACE OF DEATH

County Jasper Registration District No. 411
Township Osceola Primary Registration District No. 2002
City Joplin (No. Freeman Hospital St. _____ Ward _____)

2. FULL NAME

(a) Residence, No. Waco, Mo. 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 7 - 1924

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
13 ✓ ✓ 2

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. School boy
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) Waco, Mo

FATHER 13. NAME Wesley Calvin Sigars

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

MOTHER 15. MAIDEN NAME Eva Nichols

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Nebraska

17. INFORMANT (ADDRESS) Lester Sigars

18. BURIAL, CREMATION, OR REMOVAL PLACE Waco, Mo. DATE 11-11 1937

19. UNDERTAKER (ADDRESS) Webb City Und. Co.
Webb City, Mo

20. FILED 11-10 1937 Ed D. Jones Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-- 9 1937

22. I HEREBY CERTIFY, That I attended deceased from 11-1 1937, to 11-9 1937

I last saw him alive on 11-9 1937. Death is said to have occurred on the date stated above, at 2:45 p.m.

The principal cause of death and related causes of importance were as follows:

General Septicemia
(Streptococcus - Shit Chan)
infection - sore throat

Other contributory causes of importance: 15 C
Blood cultures

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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? _____

If so, specify _____

(Signed) Ed D. Jones, M. D.

(Address) Joplin

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

415-79
Do not use this space.

1. PLACE OF DEATH

(a) County Jasper Registration District No. 411
 (b) Township Primary Registration District No. 3602
 (c) City Joplin (d) Street No. St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Henry Dale Sugar

(a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S

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.
13 2

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as 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)

FATHER
 13. NAME

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

MOTHER
 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-9-1932

22. I HEREBY CERTIFY, That I attended deceased from 19 to 19

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at..... m.

The principal cause of death and related causes of importance were as follows:

General Septicemia
Infection
Strep sore throat

Date of onset

Other contributory causes of importance:

Name of operation 1150 Date of.....
 What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? None Date of injury Nov 9 19

Where did injury occur? None
 (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury None
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?

If so, specify.....
 (Signed) E. E. Ford, M.D. M. D.
 (Address) Joplin, Mo.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. Exact statement of OCCUPATION is very important.

