

030 JUN 13 1939

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

Do not use this space.

1. PLACE OF DEATH

County Linn
Township Home
City (No. _____)

Registration District No. 469
Primary Registration District No. 5632

File No. 19059
Registered No. 8
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. Katie Sifferman SIFFERMAN St. _____ Ward _____
(Usual place of abode) Miller 1st St.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-20-1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
75 6 10

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Home widow
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) Henry Co. Ill

13. NAME Samuel Rankin

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

15. MAIDEN NAME unknown

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

17. INFORMANT Mr. Carl Sifferman (ADDRESS) Miller St.

18. BURIAL, CREMATION, OR REMOVAL PLACE Halltown DATE 4-1-1939

19. UNDERTAKER Monroe S. Searson (ADDRESS) Miller St.

20. FILED 6-1-1939 W. S. Bunn Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-31-1939

22. I HEREBY CERTIFY, That I attended deceased from 1-1-1939 to 3-31-1939
I last saw him 2 alive on 3-31-1939 Death is said to have occurred on the date stated above, at 11⁰⁰ P. M.

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

Heart Bloo Date of onset _____
gsk

Other contributory causes of importance: _____

Name of operation chronical Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? Y

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) W. S. Bunn, M. D.
(Address) Miller 1st St.

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.

X704

RECEIVED

District Health Officer No. 6,

District File Number 6-6-39-1157

Date Filed JUN 5 1939 PDL