

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

Do not use this space.

36254-A
80

1. PLACE OF DEATH

County Barry Registration District No. 27 38
 Township Shell Knob Primary Registration District No. 4077 5851
 City Shell Knob (No.) St. Ward)

2. FULL NAME Sarah Margaret Whisman

(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 Fe. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 9th, 1873.

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
56 5 13

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER Wm. Ledgerwood
 11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
 (STATE OR COUNTRY) unknown
 12. MAIDEN NAME OF MOTHER Matilda Moles
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
 (STATE OR COUNTRY) unknown

14. INFORMANT Amos Whisman
 (Address) Shell Knob Mo.

15. FILED Feb 20 1929 REGISTRAR Wm. R. Williams

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 22, 1919

17. I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1919, to Nov. 22, 1919, that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at 1:30 A.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer of stomach

46 B. (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 44 B. (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY?.....

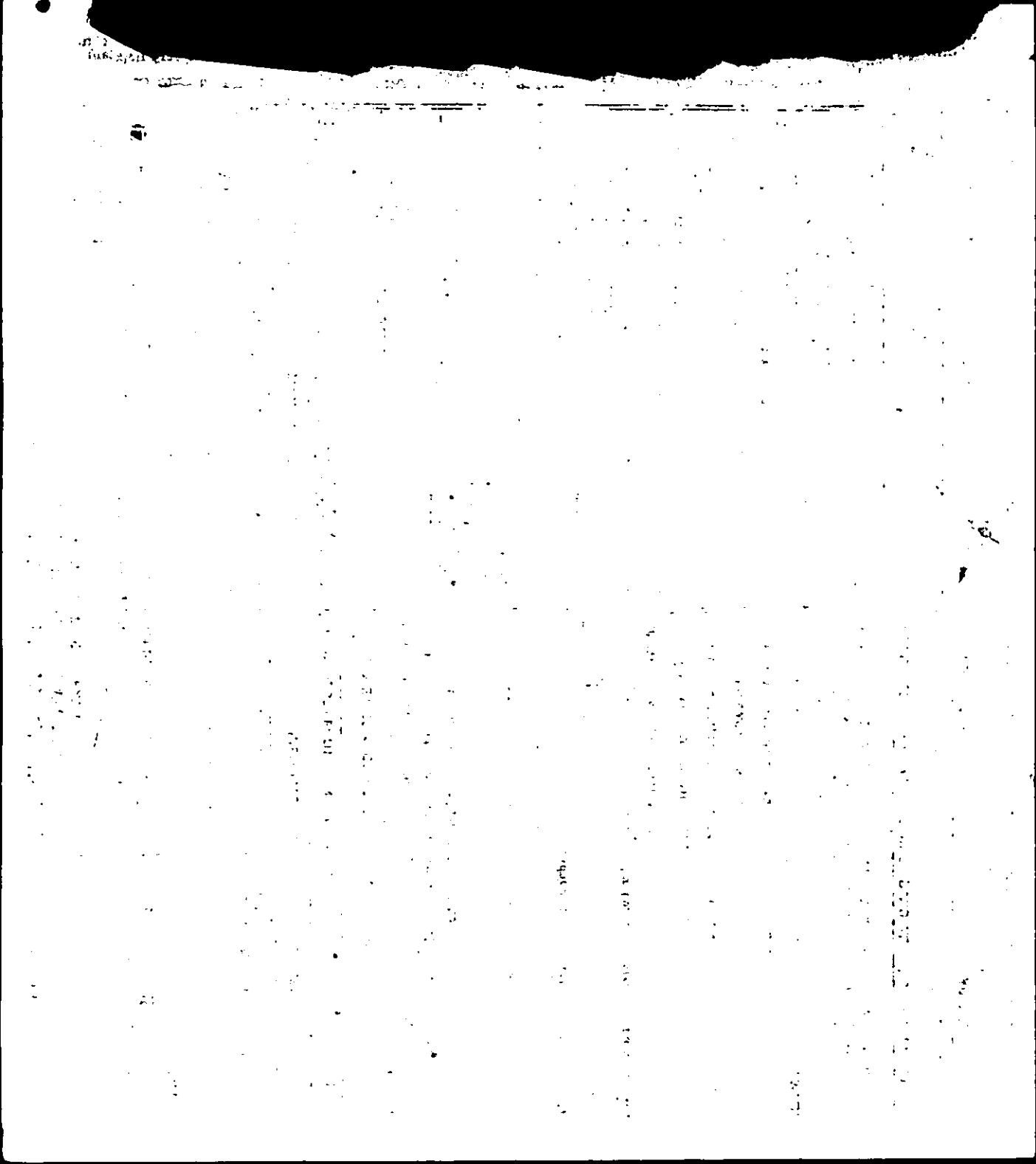
WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Wm. H. Salzer, M. D.
 19 (Address) Cassville, Mo.

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Painter DATE OF BURIAL 11-22-20

20. UNDERTAKER H Horine F. & F. Service ADDRESS Cassville

Missouri State Board of Health, Bureau of Vital Statistics, St. Louis, Mo.



**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 Barren Registration District No. 38 File No. _____
 Township Shell Knob Primary Registration District No. 5051 Registered No. _____
 City _____ (No. _____ St. _____ Ward _____)

2. FULL NAME

Sarah Margaret Whisman
 (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 <u>f</u> | 4. COLOR OR RACE <u>w</u> | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>m</u> |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Joel Whisman</u> | | |
| 6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>June 9th 1873</u> | | |
| 7. AGE YEARS <u>56</u> | MONTHS <u>5</u> | DAYS <u>13</u> |
| 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer | | |
| 9. BIRTHPLACE (CITY OR TOWN) <u>Texas</u> (STATE OR COUNTRY) | | |
| PARENTS | 10. NAME OF FATHER <u>Wm. Ledgerwood</u> | |
| | 11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Unknown</u> (STATE OR COUNTRY) | |
| | 12. MAIDEN NAME OF MOTHER <u>Martha Miles</u> | |
| 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Unknown</u> (STATE OR COUNTRY) | | |

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 22 - 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cancer of Stomach

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

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) Glenn W. Salzer, M. D.
 , 19____ (Address) Cassville

*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 <u>Painter</u> | DATE OF BURIAL <u>11-23-1929</u> |
| 20. UNDERTAKER <u>H. Horine & P. Servia</u> | ADDRESS <u>Cassville</u> |

14. INFORMANT Anna Whisman
 (Address) Shell Knob

15. FILED 11/30 1930 Anna W. Weddick
 REGISTRAR

WHITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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 of deceased if infant.

REGISTRARS SHALL NOT RECEIVE A CERTIFICATE UNTIL INDICATED BY LAW

COPIES OF THIS SUPPLEMENTARY

S-36254-A

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...