

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

PLACE OF DEATH  
County Morgan  
Township Morgan  
or Village   
or City  (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 953 File No. 9477  
Primary Registration District No. 5792-e Registered No. 6

FULL NAME Sally A. Hunter

[If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED widowed  
(Write the word)

DATE OF BIRTH May 29 1861  
(Month) (Day) (Year)

AGE 53 yrs. 9 mos. 12 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

OCCUPATION (a) Trade, profession, or particular kind of work House Keeper  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

BIRTHPLACE (City or town, State or foreign country) Arkisville Mo.

PARENTS  
NAME OF FATHER W. L. McDaniel  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo  
MAIDEN NAME OF MOTHER L. P. Snodgrass  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 11 1915  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 3-11-1915, to 3-11-1915, that I last saw her alive on Nov 29 1914, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH\* was as follows:  
Chronic Valvular Heart Disease  
92 AM

(Duration) 4 yrs. \_\_\_ mos. \_\_\_ ds.

Contributory (SECONDARY) \_\_\_\_\_  
(Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

(Signed) J. S. Wilson M. D.  
312-1915 (Address) Frontier

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

Where was disease contracted if not at place of death? \_\_\_\_\_  
Former or usual residence

PLACE OF BURIAL OR REMOVAL Liberty Cemetery DATE OF BURIAL 3-13-1915  
UNDERTAKER J. C. Patterson ADDRESS Upton Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Jack McDaniel  
(ADDRESS) Udalia Mo

Filed Mar 31 1915 J. A. Brockman REGISTRAR

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

**PLACE OF DEATH**

County \_\_\_\_\_  
 Township \_\_\_\_\_ or \_\_\_\_\_  
 Village \_\_\_\_\_ or \_\_\_\_\_  
 City \_\_\_\_\_  
 Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_  
 Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
 (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number]

**FULL NAME**

**PERSONAL AND STATISTICAL PARTICULARS**

SEX \_\_\_\_\_ COLOR OR RACE \_\_\_\_\_  
 SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_  
 WIDOWED \_\_\_\_\_ OR DIVORCED \_\_\_\_\_  
 (If file the word)

DATE OF BIRTH \_\_\_\_\_ (Month) \_\_\_\_\_, 191\_\_\_\_ (Day) \_\_\_\_\_, 191\_\_\_\_ (Year) \_\_\_\_\_  
 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. **IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?**

OCCUPATION \_\_\_\_\_  
 (a) Trade, profession, or particular kind of work  
 (b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE \_\_\_\_\_  
 (City or town, State or foreign country)

NAME OF FATHER \_\_\_\_\_

BIRTHPLACE OF FATHER \_\_\_\_\_  
 (City or town, State or foreign country)

MAIDEN NAME OF MOTHER \_\_\_\_\_

BIRTHPLACE OF MOTHER \_\_\_\_\_  
 (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) \_\_\_\_\_

(ADDRESS) \_\_\_\_\_

Filed \_\_\_\_\_ 191\_\_\_\_ REGISTRAR \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH \_\_\_\_\_ (Month) \_\_\_\_\_, 191\_\_\_\_ (Day) \_\_\_\_\_, 191\_\_\_\_ (Year) \_\_\_\_\_

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m. The CAUSE OF DEATH was as follows:

Contributory \_\_\_\_\_ (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

\_\_\_\_\_ (Address) \_\_\_\_\_ M. D.

\* State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) \_\_\_\_\_

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 191\_\_\_\_

UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_