

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

Do not use this space.

11409

1. PLACE OF DEATH

County Sullivan

Registration District No. 804

File No. ....

Township .....

Primary Registration District No. 4152e

Registered No. ....

City Osgood (No. ....)

St. .... Ward)

2. FULL NAME

Sylvester H. Todd

(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

Male

4. COLOR OR RACE

White

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

married

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

-

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 19, 1853

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, .... hrs. or .... min.

77

0

24

8. OCCUPATION OF DECEASED

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

Retired merchant

(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)

Mo.

10. NAME OF FATHER

John Todd

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Va.

12. MAIDEN NAME OF MOTHER

Maria Anderson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Va.

14.

INFORMANT

Mrs. Mattie Johnson

(Address)

Osgood Mo

15.

FILED

April 30, 1930

R. R. Jones

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March, 15, 1930

17.

I HEREBY CERTIFY, That I attended deceased from July, 1929, to March 15, 1930 that I last saw alive on March 14, 1930, and that death occurred, on the date stated above, at 1:50 a. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Myocarditis Chronic

93C

CONTRIBUTORY (SECONDARY)

Asthma

(duration) 3 yrs. .... mos. .... ds.

(duration) 6 yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, ....

19. DID AN OPERATION PRECEDE DEATH? no DATE OF U

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) U. C. Weston, M. D.

3-15-1930 (Address) Galt 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

DATE OF BURIAL

Union Grav. Osgood Mo

3-16 1930

20. UNDERTAKER

ADDRESS

R. R. Jones

Galt Mo

