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: Monroe

Township: Monroe
or
Village:
or
City: Monroe City (NO. ____ St.: ____ Ward)

Registration District No.: S-81

Primary Registration District No.: 4343

File No.: 6303

Registered No.: 8

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

FULL NAME Lucy A. Burditt

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Widowed

DATE OF BIRTH: Feby 7th (Month) (Day), 1834 (Year)

AGE: 76 yrs. 4 mos. — ds.

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

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

BIRTHPLACE (City or town, State or foreign country): Warrenton V.A. Fauquier Co

PARENTS

NAME OF FATHER: Thomas Hellery

BIRTHPLACE OF FATHER (City or town, State or foreign country): Fauquier Co V.A.

MAIDEN NAME OF MOTHER: Elizabeth Keith

BIRTHPLACE OF MOTHER (City or town, State or foreign country): V.A.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mattie Griffith.

(ADDRESS) Monroe City Mo.

Filed Mar 7, 1910. W. B. A. McNutt, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Feby. 11th (Month) (Day), 1910 (Year)

I HEREBY CERTIFY, that I attended deceased from Feby. 4, 1910, to Feby 11, 1910, that I last saw her alive on Feby 10, 1910, and that death occurred, on the date stated above, at 11 P.m.

The CAUSE OF DEATH* was as follows:

Uremic Poisoning
13 yr B
Ill (Duration) ____ yrs. ____ mos. 10 ds.

Contributory
Mania (Secondary) (Duration) 2 yrs. 1 mos. — ds.

(Signed) Geo. L. Turner M. D.

Mar 1, 1910 (Address) Monroe City Mo

*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: ✓

DATE OF BURIAL: ✓, 191__

UNDERTAKER: W. H. Wilson

ADDRESS: Monroe City Mo.

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

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village..... Primary Registration District No. ..... Registered No. .....

or

City ..... (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 (*Write* the word)

DATE OF BIRTH

....., 1.....
(Month) (Day) (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)

PARENTS

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

....., 191.....
(Month) (Day) (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:

.....

.....

.....

.....(Duration).....yrs. .....mos. .....ds.

Contributory .....
(SECONDARY)

.....(Duration).....yrs. .....mos. .....ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*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	DATE OF BURIAL ....., 191.....
UNDERTAKER	ADDRESS

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT R