

MARGIN RESERVED FOR BINDING

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 Batter  
Township Nelly  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 88 File No. 37115  
Primary Registration District No. 5130 Registered No. 15

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

FULL NAME Armeda Kennedy

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

AGE 56 yrs. X mos. X ds. IF LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

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

BIRTHPLACE (City or town, State or foreign country) Indiana

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) James Kennedy  
(ADDRESS) Nellyville

Filed Dec 19 1910 W.D. Davidson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 19 1910  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 18, 1910, to Dec 18, 1910, that I last saw her alive on Dec 18, 1910, and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH was as follows:  
Acute Broncho Pneumonia

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

(Signed) W.B. Dennis M. D.  
(Address) Nellyville, 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 X yrs. X mos. X ds. In the State X yrs. X mos. X ds.  
Where was disease contracted if not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL Roberts Cemetery DATE OF BURIAL Dec 19 1910  
UNDERTAKER James Kennedy ADDRESS Nellyville, Mo.

