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

PLACE OF DEATH

County Schuyler

Township — or Village Green City

Registration District No. 854

Primary Registration District No. 1448

File No. 36614

Registered No.

(NO. ____ St.: ____ Ward)

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

FULL NAME Charlottie Brown

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH: Dec 12 (Month) (Day), 1829 (Year)

AGE: 88 yrs. 10 mos. 6 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Retired Home wife
(b) General nature of industry, business, or establishment in which employed (or employer): 0 0

BIRTHPLACE (City or town, State or foreign country): Ind

PARENTS

NAME OF FATHER: John Burley

BIRTHPLACE OF FATHER (City or town, State or foreign country): N. Hamp

MAIDEN NAME OF MOTHER: Lucy Burley

BIRTHPLACE OF MOTHER (City or town, State or foreign country): N. Hamp

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Fred Linn

(ADDRESS) Green City Mo

Filed 10/19 1911 F B Farrington REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct 18 (Month) (Day), 1911 (Year)

I HEREBY CERTIFY, that I attended deceased from 1909, 191__, to Oct 18, 1911, that I last saw h__ alive on Oct 15, 1911, and that death occurred, on the date stated above, at 5 6 m.

The CAUSE OF DEATH* was as follows:

820 Paralysis

162 66

(Duration) 5 yrs. ____ mos. ____ ds.

Contributory (SECONDARY) Old age

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

(Signed) F B Farrington M. D.

10/19 1911 (Address) Green 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: Green City Mo

DATE OF BURIAL: Oct 19 1911

UNDERTAKER: L A Young

ADDRESS: Green City Mo

PLACE OF DEATH

County_____

Township _____
or
Village_____
or
City _____ (NO._____, _____ St.;_____ Ward)

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

Registration District No._____ File No._____

Primary Registration District No._____ Registered No._____

[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