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

PLACE OF DEATH

County Wayne

Township —

or Village —

or City Greenville, Mo (NO. — St.: — Ward)

Registration District No. 896 — File No. 40301

Primary Registration District No. 4639 — Registered No. 49

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

FULL NAME Mary Ann Brewer

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	W	widow

DATE OF BIRTH: Oct 9 (Month) (Day), 1840 (Year)

AGE: 71 yrs. — mos. 26 ds. — If LESS than 1 day, — hrs. or — min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 0-0

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

PARENTS
- NAME OF FATHER: Stephen Ledbetter
- BIRTHPLACE OF FATHER (City or town, State or foreign country): Tennessee
- MAIDEN NAME OF MOTHER: Margaret Acuff
- BIRTHPLACE OF MOTHER (City or town, State or foreign country): Tenn.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. C. Yager

(ADDRESS) Greenville Mo.

Filed Nov 13 1911 N. G. Wilson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: November 13 (Month) (Day), 1911 (Year)

I HEREBY CERTIFY, that I attended deceased from Nov. 8, 1911, to Nov 13, 1911, that I last saw he alive on Nov. 13, 1911, and that death occurred, on the date stated above, at 9 45 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

108 AM

(Duration) — yrs. — mos. 6 ds.

Contributory (SECONDARY) — (Duration) — yrs. — mos. — ds.

(Signed) John F Wagner M. D.

11-15- 1911 (Address) Greenville, 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: Hickman Cemetery — DATE OF BURIAL: 11-15- 1911

UNDERTAKER: F. M. & M. Co. — ADDRESS: Greenville Mo

CAUSE OF DEATH MUST BE WRITTEN IN PLAIN TERMS, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
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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