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

PLACE OF DEATH

County Dunklin

Township ~~Cotton Hill~~

or Village Malden

or City _____ (NO. _____ St.; _____ Ward)

Registration District No. 289 File No. 41043

Primary Registration District No. 4173 Registered No. 118

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

FULL NAME Mary M. Carzine

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: Feby (Month) 27 (Day), 1896 (Year)

AGE: 14 yrs. 9 mos. 16 ds.

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

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

BIRTHPLACE (City or town, State or foreign country): Bollinger Co. Mo.

PARENTS

NAME OF FATHER: Nathan Carzine

BIRTHPLACE OF FATHER (City or town, State or foreign country): Dont Know

MAIDEN NAME OF MOTHER: Martha Meyers

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Dont Know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. M.E. Taylor

(ADDRESS) Malden Mo.

Filed 12/13, 1911. S E Mitchell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from Dec 7, 1911, to Dec 13, 1911, that I last saw her alive on Dec 12, 1911, and that death occurred, on the date stated above, at 12.50 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

2.5 M

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

Contributory (SECONDARY) _____

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

(Signed) S E Mitchell M. D.

12-13, 1911 (Address) Malden 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: Malden Mo

DATE OF BURIAL: 12-14, 1911

UNDERTAKER: W. L. Craig

ADDRESS: Malden Mo

Revised United States Standard Certificate of Death

PLACE OF DEATH

County _____

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

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

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death oc
hospital or
give its NA
of street and

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____ (Month) _____ (Day), 1_____ (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 _____ (Month) _____ (Day)

I HEREBY CERTIFY, that I attended deceas
_____, 191____, to _____,
that I last saw h____ alive on _____,
and that death occurred, on the date stated above, at ____
The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. ____

Contributory _____
(SECONDARY)
_____ (Duration) _____ yrs. _____ mos. ____

(Signed) _____

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Cau
(1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSI
RECENT RESIDENTS)
At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____
Where was disease contracted if not at place of death? _____
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
UNDERTAKER	ADDRESS

Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless im-