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 INDELIBLE INK—THIS IS A PERMANENT RECORD

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

PLACE OF DEATH

County: Cape Girardeau

Township or Village or City: Cape Girardeau

Registration District No. 125 — File No. 426

Primary Registration District No. 3009 — Registered No. 234

(NO. ____, ____ St.; ____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME: William Mc Clatchey

**PERSONAL AND STATISTICAL PARTICULARS**

SEX: Male

COLOR OR RACE: White

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

DATE OF BIRTH: Oct 1st, 1844 (Month) (Day) (Year)

AGE: 67 yrs. 3 mos. 28 ds. — If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Retired Steamboat Captain
(b) General nature of industry, business, or establishment in which employed (or employer): N-A

BIRTHPLACE (City or town, State or foreign country): Penn.

PARENTS
NAME OF FATHER: Sam. Mc Clatchey
BIRTHPLACE OF FATHER (City or town, State or foreign country): Ind.
MAIDEN NAME OF MOTHER: Magrate Briggs
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Don't Know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Sam. Mc Clatchey
(ADDRESS): Cape Girardeau Mo.

Filed Jan. 29, 1912 — Geo. E. Chappell, REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH: January 29, 1912 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 8, 1911, to January 29, 1912, that I last saw him alive on January 10, 1912, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:
Mitral Regurgitation
grip

(Duration) 3 yrs. ____ mos. ____ ds.

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

(Signed) R. F. Richards M. D.
Jan 29 1912 (Address) Cape Girardeau

*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: St Marys Cem.
DATE OF BURIAL: Jan 31st 1912
UNDERTAKER: R. Walther
ADDRESS: Cape Girardeau Mo

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 HEALTI
## 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 hospital or institutio give its NAME inste 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 fro

....., 191...., to ....., 191....

that I last saw h..... alive on ....., 191....

and that death occurred, on the date stated above, at .....n

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs. .....mos. .....d

Contributory .....
(SECONDARY)

.....(Duration).....yrs. .....mos. .....d

(Signed) ..... M. I

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

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, RECENT RESIDENTS)

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos. .....d

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 |