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: Livingston

Township: Cream Ridge

or Village:

or City: ~~Chillicothe~~ (NO. ..... St. ..... Ward)

Registration District No. 509 — File No. 26776

Primary Registration District No. 5677 — Registered No. 17

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

FULL NAME Henry Grime

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

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

DATE OF BIRTH: Jan. (Month) 5 (Day), 1847 (Year)

AGE: 65 yrs. 5 mos. 27 ds.

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

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

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

PARENTS
NAME OF FATHER: Peter Grime
BIRTHPLACE OF FATHER (City or town, State or foreign country): France
MAIDEN NAME OF MOTHER: Mary Pirson
BIRTHPLACE OF MOTHER (City or town, State or foreign country): France

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jack McKinzie

(ADDRESS) Linda Mo.

Filed Aug 10th 1912 Thos. E. Graham M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: July (Month) 2 (Day), 1912 (Year)

I HEREBY CERTIFY, that I attended deceased from Mch. 7, 1912, to July 2, 1912, that I last saw him alive on July 2, 1912, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum.

(Duration) ___ yrs. 4 mos. ___ ds.

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

(Signed) W. M. Gardner M. D.

July 3, 1912 (Address) Chillicothe 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: Catholic Cemetery

DATE OF BURIAL: July 4, 1912

UNDERTAKER: J Mohra & Son

ADDRESS: Chillicothe Mo

PLACE OF DEATH

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

County.....

Township ..... Registration District No..... File No.....

or

Village..... Primary Registration District No..... Registered No.....

or

City .....(NO....., ...St.:.....Ward)

[If death occ
hospital or
give its NAM
of street and n

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

.....
(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 BURIA
UNDERTAKER	ADDRESS