WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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 Greene

Township Walnut Grove

or Village ~~Phenix~~

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

Registration District No. 325

Primary Registration District No. 5450

File No. 29352

Registered No. 12

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

FULL NAME Mollie Gillians

PERSONAL AND STATISTICAL PARTICULARS

SEX Female

COLOR OR RACE American

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) married

DATE OF BIRTH Feb (Month) 18 (Day), 1882 (Year)

AGE 32 yrs. 6 mos. 18 ds.

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

OCCUPATION
(a) Trade, profession, or particular kind of work House Keeping

(b) General nature of industry, business, or establishment in which employed (or employer) G-O

BIRTHPLACE (City or town, State or foreign country) Greene Co Mo

PARENTS

NAME OF FATHER James Mathews

BIRTHPLACE OF FATHER (City or town, State or foreign country) Greene Co Mo

MAIDEN NAME OF MOTHER Louisa Teck

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Greene Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hiram Gillians

(ADDRESS) Phenix Mo

Filed Sept 6, 1912 L. E. McClure REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sep (Month) 5 (Day), 1912 (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 14, 1912, to Sep 5, 1912, that I last saw her alive on Sep 5, 1912, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Hemorrhage caused by Placenta Praevia

144A

144B

(Duration) ___ yrs. ___ mos. 21 ds.

Contributory (SECONDARY) _____

(Duration) ___ yrs. ___ mos. 21 ds.

(Signed) J K Perry M. D.

Sep 5, 1912 (Address) Walnut Grove 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 Williamson Cemetery

DATE OF BURIAL Sept 6, 1912

UNDERTAKER None

ADDRESS

MISSOURI STATE BOARD OF HEALTH
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 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

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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