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: North

Township: Fletcher

or Village:

or City: (NO. ____ St.: ____ Ward)

Registration District No. 903 File No. 35183

Primary Registration District No. 6212 Registered No. 19

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

FULL NAME Mrs J. W. De Witt

PERSONAL AND STATISTICAL PARTICULARS

SEX: Fem. COLOR OR RACE: White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): married

DATE OF BIRTH: July (Month) 8 (Day), 1864 (Year)

AGE: 48 yrs. 3 mos. 9 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country): Near Grant City Mo

PARENTS
NAME OF FATHER: J. H. Thompson
BIRTHPLACE OF FATHER (City or town, State or foreign country): Kentucky
MAIDEN NAME OF MOTHER: Mary Williamson
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Kentucky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J W Dewitt

(ADDRESS) Grant City Mo B.F.

Filed Oct 31, 1912 John Andrews REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct (Month) 18 (Day), 1912 (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 11, 1912, to Oct 17, 1912, that I last saw her alive on Oct 17, 1912, and that death occurred, on the date stated above, at about 9 a.m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis
SVH

(Duration) — yrs. — mos. 16 ds.

Contributory (SECONDARY) History of healed tuberculosis lesion (Duration) — yrs. — mos. — ds.

(Signed) O. P. M. Miller M. D.

Oct 30, 1912 (Address) Grant City 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: Fletcher Cemetery

DATE OF BURIAL: Oct 20, 1912

UNDERTAKER: Orr Prugh

ADDRESS: Grant City

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

N. ery item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state USE 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.....

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