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

653

PLACE OF DEATH

County: Clay

Township: ~~F. R~~ or Village: or City: Mo. City. Mo. (NO. ____ St.: ____ Ward)

Registration District No. 202 File No. 1

Primary Registration District No. 4121 Registered No. ____

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

FULL NAME: Mrs. Armento F. Blythe

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: white

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

DATE OF BIRTH: March (Month) 17 (Day), 1856 (Year)

AGE: 56 yrs. 10 mos. 9 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): + [illegible]

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

PARENTS
NAME OF FATHER: L. F. Robinson
BIRTHPLACE OF FATHER (City or town, State or foreign country): Virginia
MAIDEN NAME OF MOTHER: Catherine - Hamilton
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ky.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Jas. Foley

(ADDRESS) Kansas City Mo.

Filed Jan 26, 1913, W. L. Wysong REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: [illegible] January (Month) 24 (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 11, 1913, to Jan 25, 1913, that I last saw her alive on Jan 25, 1913, and that death occurred, on the date stated above, at 1230 P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

108 [illegible]

(Duration) ____ yrs. ____ mos. 14 ds.

Contributory (SECONDARY): Lobar Pneumonia

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

(Signed) W. L. Wysong M. D.

1-27, 1913 (Address) Mo. 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 40 yrs. ____ mos. ____ ds. In the State 56 yrs. 10 mos. 9 ds.

Where was disease contracted if not at place of death? At Place of Death

Former or usual residence: usual Residence

PLACE OF BURIAL OR REMOVAL: Mo City Mo

DATE OF BURIAL: 1-27, 1913

UNDERTAKER: Hill

ADDRESS: Liberty Mo

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

PLACE OF DEATH

County.....

Township ..... or Village ..... or City ..... (NO. ....., ... St.: ..... Ward)

Registration District No. .....

Primary Registration District No. .....

File No. .....

Registered No. .....

[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

..... (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

....., *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

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.

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