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 Dunklin

Township Salem

or

Village ~~Arbyrd Mo~~

or

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

Registration District No. 290 File No. 871

Primary Registration District No. 5408 Registered No. 3

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

FULL NAME Mollie Ea Fox

**PERSONAL AND STATISTICAL PARTICULARS**

SEX Female

COLOR OR RACE White

~~SINGLE~~ ~~MARRIED~~ WIDOWED ~~OR DIVORCED~~ (Write the word) Widow

DATE OF BIRTH Jan. (Month) 28 (Day) 1853 (Year)

AGE 60 yrs. 11 mos. 24 ds.

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

OCCUPATION (a) Trade, profession, or particular kind of work House keeper or House wife in husbands life time

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

BIRTHPLACE (City or town, State or foreign country) Illinois

PARENTS

NAME OF FATHER Frank Donaldson

BIRTHPLACE OF FATHER (City or town, State or foreign country) Canttell

MAIDEN NAME OF MOTHER Mary Dickey

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ill.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edgar Fox

(ADDRESS) Arbyrd Mo.

Filed 1/4, 1913. W E Handley REGISTRAR

**MEDICAL CERTIFICATE OF DEATH** 3

DATE OF DEATH Jan. (Month) 4 (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 3, 1913, to Jan 4", 1913, that I last saw her alive on Jan 3", 1913, and that death occurred, on the date stated above, at 10 A.m.

The CAUSE OF DEATH* was as follows:

Deep Seated Labor Pneumonia complicated with Nervous prostration & Asthma 108

(Duration) 112 yrs. mos. 7 ds.

Contributory (SECONDARY) 87B

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

(Signed) W. H. Russell M. D.

Jan. 4, 1913 (Address) Byrds 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 Lick Creek Chapel Cem

PLACE OF BURIAL OR REMOVAL Lick Creek Cemetery

DATE OF BURIAL 1/6, 1913

UNDERTAKER C P McDaniel

ADDRESS Senath Mo.

Death occurred at Arbyrd Cant give no. of district W. Russell M.D.

# 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** .....

**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.**

## 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** |
| | |