

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.

PLACE OF DEATH

County LinnTownship Conover

or

Village Stanbury

or

City Stanbury (NO. _____ St. _____ Ward _____)FULL NAME Mary Jane Smith

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 314File No. 49554Primary Registration District No. 4190Registered No. 3

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

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED widow
(Write the word)

DATE OF BIRTH Sept. 4, 1873AGE 58 yrs. 6 mos. 10 ds.

IF LESS than
1 day, ____ hrs.
or ____ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work 9-0(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

BIRTHPLACE

(City or town, State or foreign country) MissouriNAME OF FATHER John Lutes

BIRTHPLACE OF FATHER

(City or town, State or foreign country) Mo.MAIDEN NAME OF MOTHER Mary Ann Lutes

BIRTHPLACE OF MOTHER

(City or town, State or foreign country) Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary E. Spencer(ADDRESS) East St. Stanbury Mo.Filed Feb. 14, 1913REGISTRAR C. H. McClain

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb. 14, 1913

(Month)

(Day)

(Year)

I HEREBY CERTIFY, that I attended deceased from Jan 14th, 1913, to Feb. 14, 1913, that I last saw her alive on Feb. 13, 1913, and that death occurred, on the date stated above, at ____ m. The CAUSE OF DEATH* was as follows:

Lungs11 B

Contributory

(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed) C. H. McClain

M. D.

Feb. 14, 1913(Address) Stanbury

*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? Stanbury

Former or usual residence

PLACE OF BURIAL OR REMOVAL HigginsvilleDATE OF BURIAL Feb. 15, 1913UNDERTAKER John CunninghamADDRESS Stanbury Mo

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

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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. _____ File No. _____
Primary Registration District 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 _____ (If file the word)

DATE OF BIRTH _____ (Month) _____, 191____ (Day) _____, 191____ (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)

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) _____, 191____ (Day) _____, 191____ (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) _____, 191____ (Address) _____ M. D.

*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. 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 _____