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 Lafayette

Township or Village Washington or City ____ (No. ____ St.: ____ Ward)

Registration District No. 46 2 — File No. 9700

Primary Registration District No. 5626 — Registered No. 32

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

FULL NAME Nimrod Alkire

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	Wht	Widower

DATE OF BIRTH: Nov (Month) 9 (Day) 1837 (Year)

AGE: 76 yrs. 4 mos. 15 ds. — If LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE (City or town, State or foreign country): Va - Lafayette

PARENTS

NAME OF FATHER: John Alkire

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

MAIDEN NAME OF MOTHER: Elizabeth Neff

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Va

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E E McBurney

(ADDRESS) Odessa

Filed Mar 30 1913 W. F. Davis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Mch (Month) 26 (Day) 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from Mch 25 1913, to Mch 26, 1913, that I last saw h[illegible] alive on Mch 25, 1913, and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Neuralgia

with

(Duration) ____ yrs. ____ mos. 2 ds.

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

(Signed) R L Sproales M. D.

Mch 26 1913 (Address) Fayetteville 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: Oak Grove Cem — DATE OF BURIAL: ____ 191_

UNDERTAKER: C E Trather — ADDRESS: Odessa

PLACE OF DEATH

County Lafayette

Township Washington
or
Village
or
City (NO. , St.; Ward)

MISSOURI STATE BOARD C
BUREAU OF VITAL STATI
CERTIFICATE OF DEATH

Registration District No. File No.

Primary Registration District No. Registered No.

[Approved by U. S. Census and American Public Health

Revised United States Standard Certificate of Death

FULL NAME Mi[illegible]od Albire

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	Wht	Widower

DATE OF BIRTH March (Month) 26 (Day) 1913 (Year)

AGE [illegible] 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
(Month)

I HEREBY CERTIFY, that I attende
, 191 , to
that I last saw h alive on
and that death occurred, on the date stated abo
The CAUSE OF DEATH* was as follows:

(Duration) yrs.

Contributory
(SECONDARY)
(Duration) yrs.

(Signed)

, 191 (Address)

*State the Disease Causing Death, or, in deaths from (1) Means of Injury; and (2) whether Accidental, Suicidal, or Hor

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTION RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL | DATE

UNDERTAKER | ADDRE