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 Nodaway

Township Nodaway or Village ____ or City ~~Burl Junct Mo~~ (NO. ____, ____ St.: ____ Ward)

Registration District No. 618 File No. 13913-C

Primary Registration District No. 5820 Registered No. ____

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

FULL NAME Mary C. Westfall

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

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

DATE OF BIRTH: May 12, 1875 (Month) (Day) (Year)

AGE: 37 yrs. 11 mos. 24 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country): Manard Co Ill

PARENTS

NAME OF FATHER: T. C. Dodds

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

MAIDEN NAME OF MOTHER: L. S. Colby

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Westfall

(ADDRESS) Burlington Jct. Mo

Filed Apr. 6, 1913. C. G. Dean REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: April 6, 1913 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Apr. 6, 1913, to April 6, 1913, that I last saw her alive on April 6, 1913, and that death occurred, on the date stated above, at 10 P.m.

The CAUSE OF DEATH* was as follows:

Placenta Previa

14 H.P.

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

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

(Signed) C. G. Dean M. D.

Apr 6, 1913 (Address) Burl. Jct. 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: Ohio Cemetery

DATE OF BURIAL: Apr 9, 1913

UNDERTAKER: T. E. Fordyce

ADDRESS: Burl Jc Mo

Revised United States Standard Certificate of Death

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

PLACE OF DEATH

County.....

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

MISSOURI STATE BOARD
BUREAU OF VITAL STA
CERTIFICATE OF DEA

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

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 DEA

DATE OF DEATH

..... (Month)

I HEREBY CERTIFY, that I attend

....., 191...., to .....

that I last saw h.....alive on .....

and that death occurred, on the date stated al

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 Ho

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIO 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