

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 Wayne

Township _____

or

Village _____

or

City Piedmont (NO. _____)Registration District No. 891File No. 15537Primary Registration District No. 4540

Registered No. _____

St. _____ Ward _____

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

FULL NAME Margaret Elizabeth Abernathy

PERSONAL AND STATISTICAL PARTICULARS

SEX FemaleCOLOR OR RACE WhiteSINGLE
MARRIED widow
WIDOWED
OR DIVORCED
(Write the word)DATE OF BIRTH Dec. 5, 1838

(Month)

(Day)

(Year)

AGE 75 yrs. 4 mos. 9 ds.IF LESS than
1 day, ____ hrs.
or ____ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work Housewife(b) General nature of industry, business, or establishment in which employed (or employer) 905

BIRTHPLACE

(City or town, State or foreign country) Nashville Tenn

PARENTS

NAME OF FATHER Mathew NelsonBIRTHPLACE OF FATHER Nashville TennMAIDEN NAME OF MOTHER Kathrine EpelyBIRTHPLACE OF MOTHER known

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Kate Winters(ADDRESS) St Louis Mo.Filed Apr 27, 1913

REGISTRAR

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 15, 1913

(Month)

(Day)

(Year)

I HEREBY CERTIFY, that I attended deceased from Apr 7, 1913, to Apr 15, 1913, that I last saw her alive on Apr 15, 1913, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

Contributory (SECONDARY)

(Duration) ____ yrs. ____ mos. 8 ds.(Signed) S. W. Toney

M. D.

(Address) Piedmont

*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 PiedmontDATE OF BURIAL Apr 16, 1913UNDERTAKER Chas. S. HiestADDRESS Piedmont

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: _____

Township _____

or

Village _____

or

City _____ (NO. _____)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

St. _____ Ward _____

(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), 191_____ (Year)		
AGE	IF LESS than 1 day, _____ hrs. or _____ min.?	
_____ yrs. _____ mos. _____ ds.		
OCCUPATION		
(a) Trade, profession, or particular kind of work _____		
(b) General nature of industry, business, or establishment in which employed (or employer) _____		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (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:

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) _____

Contributory (SECONDARY)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____

(Address) _____ 191_____ 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, TRANSMIENTS, 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

UNDERTAKER

ADDRESS

Filed _____

191_____

REGISTRAR