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: Morgan

Township: _____ or Village: _____ or City: Versailles (NO. _____ St.: _____ Ward)

Registration District No. 598 File No. 23597

Primary Registration District No. 4355 Registered No. 27

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

FULL NAME Mary Lucinda Handy

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

~~MARRIED~~ ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word): Single

DATE OF BIRTH: July 19 (Month) (Day), 1895 (Year)

AGE: 18 yrs. ____ mos. 6 ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE (City or town, State or foreign country): Virginia

PARENTS
NAME OF FATHER: Sherman Handy
BIRTHPLACE OF FATHER (City or town, State or foreign country): Virginia
MAIDEN NAME OF MOTHER: Lucy Ellen Hark
BIRTHPLACE OF MOTHER (City or town, State or foreign country): North Car.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Myrtle Handy

(ADDRESS) Versailles Mo.

Filed July 27, 1913 H. N. Lutman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: July 25 (Month) (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from July 6, 1913, to July 25, 1913, that I last saw her alive on July 25, 1913, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

1. Typhoid fever

(Duration) ____ yrs. ____ mos. 18 ds.

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

(Signed) A. J. Gunn M. D.

July 26, 1913 (Address) Versailles 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: Versailles, Mo

DATE OF BURIAL: July 27, 1913

UNDERTAKER: Ed Munson

ADDRESS: Versailles

Revised United States Standard Certificate of Death

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

MISSOURI STATE BOARD O
BUREAU OF VITAL STATI
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)

[hos giv of

FULL NAME.....

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

.....
(Month)

I HEREBY CERTIFY, that I attende

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

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

and that death occurred, on the date stated at

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 H

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	ADDRI