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: Adair

Township: ____ or Village: ____ or City: Kirksville (NO. 612 N. Franklin St.; 1 Ward)

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

Registration District No.: 4 File No.: 28882

Primary Registration District No.: 30 06 Registered No.: 105

FULL NAME: James Adams Carlisle

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: white

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

DATE OF BIRTH: April 22, 1851 (Month) (Day) (Year)

AGE: 62 yrs. 5 mos. 5 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): Harness Shop

BIRTHPLACE (City or town, State or foreign country): Coulterville Ill.

PARENTS

NAME OF FATHER: Herbert Carlisle

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

MAIDEN NAME OF MOTHER: Mary Adams

BIRTHPLACE OF MOTHER (City or town, State or foreign country): don't know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Mrs. Anna L. Gates

(ADDRESS): Kirksville Mo.

Filed Sep 27, 1913. A W Parrish REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Sept 27 (Month) (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from June, 1911, to Sep 27, 1913, that I last saw him alive on Sep 26, 1913, and that death occurred, on the date stated above, at 5:55 a m.

The CAUSE OF DEATH* was as follows:

Parenchymatous Nephritis Chronic

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

Contributory (SECONDARY) Mitral insufficiency

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

(Signed) A W Parrish M. D.

Sep 27, 1913 (Address) Kirksville 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: Forest Cemetery

DATE OF BURIAL: Sept 28, 1913

UNDERTAKER: H. C. Wilson

ADDRESS: Kirksville Mo

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. _____, _____ 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 (*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 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:

_____

_____

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

Contributory (SECONDARY) _____

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

(Signed) _____ M. D.

_____, 191__ (Address) _____

*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	DATE OF BURIAL _____, 191__
UNDERTAKER	ADDRESS