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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Macon

Township Jackson or Village or City ~~Near Atlanta Mo~~ (No. ______ St.; ______ Ward)

Registration District No. 970 File No. 30302

Primary Registration District No. 5702 Registered No. ______

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

FULL NAME Lucinda Angle

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

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

DATE OF BIRTH: Oct 3, 1849 (Month) (Day) (Year)

AGE: 64 yrs. 11 mos. 26 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): 9-0

BIRTHPLACE (City or town, State or foreign country): New York

PARENTS
NAME OF FATHER: Oran Baldwin
BIRTHPLACE OF FATHER (City or town, State or foreign country): Conn
MAIDEN NAME OF MOTHER: Emma Ford
BIRTHPLACE OF MOTHER (City or town, State or foreign country): New York

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. W. Angle

(ADDRESS) Atlanta

Filed Sept 30 1913 W B Hall REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Sept 28, 1913 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 1, 1913, to Sept 28, 1913, that I last saw her alive on Sept 27, 1913, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis with Chronic Cystitis

131
135 B

(Duration) 6 yrs. — mos. — ds.

Contributory (Secondary) ______ (Duration) — yrs. — mos. — ds.

(Signed) A L Cambre M. D.

Sept 29, 1913 (Address) Atlanta 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: Mt Tabor

DATE OF BURIAL: Sept 28 1913

UNDERTAKER: H M Goodding

ADDRESS: Atlanta Mo

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
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)

[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

_____, 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

_____, 191____
(Month) (Day) (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

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD