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

**PLACE OF DEATH**

County Pettis

Township ____ or Village ____ or City Sedalia (NO. 1515 S. Stewart St.; ____ Ward)

Registration District No. 668 File No. 37062

Primary Registration District No. 2032 Registered No. 282

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

**FULL NAME** Mary Elizabeth Whitmire

**PERSONAL AND STATISTICAL PARTICULARS**

| SEX | COLOR OR RACE | SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) |
|---|---|---|
| Fem. | White | Married |

DATE OF BIRTH: Mar. 28 (Month), ____ (Day), 1852 (Year)

AGE: 61 yrs. 8 mos. ____ ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

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

PARENTS
- NAME OF FATHER: Thomas Brown
- BIRTHPLACE OF FATHER (City or town, State or foreign country): Pa.
- MAIDEN NAME OF MOTHER: Johanna Mellon
- BIRTHPLACE OF MOTHER (City or town, State or foreign country): Pa.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. H. Whitmire

(ADDRESS) Sedalia Mo.

Filed Nov 25 1913. A. B. Long REGISTRAR

**2. MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH: Nov (Month) 24 (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 9, 1913, to Nov 24, 1913, that I last saw h[er] alive on Nov 24, 1913, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

22 Tetanus

181

(Duration) 1 yrs. 1 mos. 3 ds.

Contributory (SECONDARY) Burns (Duration) 1 yrs. 1 mos. 17 ds.

(Signed) W. T. Cherry M. D.

11-25, 1913 (Address) Sedalia 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 | DATE OF BURIAL |
|---|---|
| Sedalia Mo. | 11-27-, 1913 |
| **UNDERTAKER** | **ADDRESS** |
| Sedalia Undtk. Co. | Sedalia |

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

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### CERTIFICATE OF DEATH

**PLACE OF DEATH**

County.....

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

Registration District No.....

Primary Registration District No.....

File No.....

Registered No.....

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

**FULL NAME**.....

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**PERSONAL AND STATISTICAL PARTICULARS**

| SEX | COLOR OR RACE | SINGLE<br>MARRIED<br>WIDOWED<br>OR DIVORCED<br>(*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

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**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<br>....., 191..... |
|---|---|
| UNDERTAKER | ADDRESS |

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**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.**