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## PLACE OF DEATH

County

Township

or

Village

or

City

Registration District No.

Primary Registration District No.

File No.

Registered No.

St. 38 Ward

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

FULL NAME Rachael S. Earp

## PERSONAL AND STATISTICAL PARTICULARS

SEX

female

COLOR OR RACE

whiteSINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)married

DATE OF BIRTH

Sept. - 4, 1837  
(Month) (Day) (Year)

AGE

76 yrs. 2 mos. ds.If LESS than  
1 day, \_\_\_ hrs.  
or \_\_\_ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work

none

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

none

BIRTHPLACE

(City or town, State or foreign country)

Missouri

PARENTS

NAME OF FATHER

Joseph Shepherd

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Kentucky

MAIDEN NAME OF MOTHER

Mary Maddox

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Kentucky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

David Earp

(ADDRESS)

Sedalia, Mo.

Filed

Dec. 2, 1913H. B. Long

REGISTRAR

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

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

12, 1913  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 11-30, 1911, to 11-30, 1913, that I last saw her alive on 12-1, 1912, and that death occurred, on the date stated above, at P m. The CAUSE OF DEATH\* was as follows:

Apoplexy

Contributory (SECONDARY)

(Duration) yrs. mos. 2 ds.(Duration) yrs. mos. 2 ds.

(Signed)

B. H. Crawford M. D.  
12-9, 1913 (Address) 540 Ohio Ave.

\*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

Antioch Cemetery

UNDERTAKER

W. H. Smith

DATE OF BURIAL

Dec. 3, 1913

ADDRESS

Sedalia, Mo.

## PLACE OF DEATH

County \_\_\_\_\_

Township \_\_\_\_\_

or

Village \_\_\_\_\_

or

City \_\_\_\_\_

Registration District No. \_\_\_\_\_

File No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registered No. \_\_\_\_\_

(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                            |                                                                                                  | MEDICAL CERTIFICATE OF DEATH                                                                                                                         |  |
|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| SEX                                                             | COLOR OR RACE                                                                                    | DATE OF DEATH                                                                                                                                        |  |
|                                                                 | SINGLE<br>MARRIED<br>WIDOWED<br>OR DIVORCED<br>(If not the word)                                 |                                                                                                                                                      |  |
| DATE OF BIRTH                                                   | (Month) _____ (Day) _____ (Year) _____                                                           | I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____;                                                                   |  |
| AGE                                                             | IF LESS than<br>1 day, _____ hrs.<br>or _____ min.?                                              | that I last saw h_____ alive on _____, 191____,                                                                                                      |  |
| OCCUPATION                                                      | (a) Trade, profession, or particular kind of work _____                                          | and that death occurred, on the date stated above, at _____ m.                                                                                       |  |
|                                                                 | (b) General nature of industry, business, or establishment in which employed (or employer) _____ | The CAUSE OF DEATH* was as follows:                                                                                                                  |  |
| BIRTHPLACE                                                      | (City or town, State or foreign country) _____                                                   | (Duration) _____ yrs. _____ mos. _____ ds.                                                                                                           |  |
| NAME OF FATHER                                                  | _____                                                                                            | Contributory (SECONDARY) _____                                                                                                                       |  |
| BIRTHPLACE OF FATHER                                            | (City or town, State or foreign country) _____                                                   | (Duration) _____ yrs. _____ mos. _____ ds.                                                                                                           |  |
| MAIDEN NAME OF MOTHER                                           | _____                                                                                            | (Signed) _____ M. D. _____                                                                                                                           |  |
| BIRTHPLACE OF MOTHER                                            | (City or town, State or foreign country) _____                                                   | * State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. |  |
| THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____ |                                                                                                  | LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)                                                                   |  |
| (ADDRESS) _____                                                 |                                                                                                  | 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                                                                                                                                            |  |

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

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