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.

Henry Busker

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

PLACE OF DEATH

County Pettis

Township Flatwoods

or

Village

or

City (NO. Valdo Mo. St.; Ward)

Registration District No. 668 File No. 5675

Primary Registration District No. 5890 Registered No. 54

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

FULL NAME Jno M Bishop

PERSONAL AND STATISTICAL PARTICULARS

SEX M

COLOR OR RACE W

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widower

DATE OF BIRTH Feb 12, 1825 (Month) (Day) (Year)

AGE 88 yrs. 5 mos. 13 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

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

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

BIRTHPLACE (City or town, State or foreign country) Ill

PARENTS

NAME OF FATHER Geo W Bishop

BIRTHPLACE OF FATHER (City or town, State or foreign country) Indiana

MAIDEN NAME OF MOTHER Eva Lewis

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ill

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Bishop

(ADDRESS) Sedalia Mo.

Filed Feb 25, 1914 F. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 22, 1914 (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 4 P m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

131 (Died suddenly)

132 B (Duration) 1 yrs. ___ mos. ___ ds.

Contributory (SECONDARY) uremic pasion.

(Duration) ___ yrs. ___ mos. ___ ds.

X (Signed) D P Dyer Coroner M. D.

7/24, 1914 (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 Syracuse Mo

DATE OF BURIAL 2-25, 1914

UNDERTAKER Sedalia Undt & Cst Co

ADDRESS Sedalia

PLACE OF DEATH

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

Revised United States Standard Certificate

County.....

Township ..... Registration District No. ..... File No. .....
or
Village..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. .... St.; ..... Ward)

[If death occurred hospital or instit give its NAME in of street and numb

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

....., 19
(Month) (Day) (Y

I HEREBY CERTIFY, that I attended deceased f

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

that I last saw h.....alive on....., 191

and that death occurred, on the date stated above, at.....

The CAUSE OF DEATH* was as follows:

.....(Duration).....yrs. .....mos.

Contributory.....
(SECONDARY)

.....(Duration).....yrs. .....mos.

(Signed)..... M

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, s (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS RECENT RESIDENTS)

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos.

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