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

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

PLACE OF DEATH

County Henry

Township Hudson or Village or City (No. St.; Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

Registration District No. 354 File No. 8318

Primary Registration District No. 5496 Registered No. 16

FULL NAME Lena Roth Brown

PERSONAL AND STATISTICAL PARTICULARS	
SEX	F
COLOR OR RACE	White
SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)	Married
DATE OF BIRTH (Month) (Day) (Year)	Dont know, 1890
AGE	24 yrs. 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)	Pettis Co Mo.
PARENTS: NAME OF FATHER	John Roth
BIRTHPLACE OF FATHER (City or town, State or foreign country)	Switzerland
MAIDEN NAME OF MOTHER	Unknown
BIRTHPLACE OF MOTHER (City or town, State or foreign country)	Switzerland

948
85

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W G Acker

(ADDRESS) Kingston Mo.

Filed Mch 14, 1914 R J Jennings REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 13, 1914 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 13, 1914, to March 13, 1914, that I last saw her alive on March 13, 1914, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Plocking of Coronary Artery

(Duration) yrs. mos. ds.

Contributory (Secondary) Epilepsy

(Duration) yrs. mos. ds.

(Signed) R J Jennings M.D.

March 13, 1914 (Address) Windsor 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 Windsor Mo.

DATE OF BURIAL Mch 14 1914

UNDERTAKER W E Hutton

ADDRESS Windsor 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 ______ 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	MEDICAL CERTIFICATE OF DEATH
SEX / COLOR OR RACE / SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word)	DATE OF DEATH ______ (Month) (Day), 191__ (Year)
DATE OF BIRTH ______ (Month) (Day), 1____ (Year)	I HEREBY CERTIFY, that I attended deceased from ______, 191__, to ______, 191__
AGE ______ yrs. ______ mos. ______ ds. — If LESS than 1 day, ___ hrs. or ___ min.?	that I last saw h___ alive on ______, 191__, and that death occurred, on the date stated above, at ______ m.
OCCUPATION (a) Trade, profession, or particular kind of work ______	The CAUSE OF DEATH* was as follows: ______
(b) General nature of industry, business, or establishment in which employed (or employer) ______	______ (Duration) ______ yrs. ______ mos. ______ ds.
BIRTHPLACE (City or town, State or foreign country)	Contributory (SECONDARY) ______ (Duration) ______ yrs. ______ mos. ______ ds.
PARENTS — NAME OF FATHER	(Signed) ______ M. D.
PARENTS — BIRTHPLACE OF FATHER (City or town, State or foreign country)	______, 191__ (Address) ______
PARENTS — MAIDEN NAME OF MOTHER	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
PARENTS — BIRTHPLACE OF MOTHER (City or town, State or foreign country)	LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE	Where was disease contracted if not at place of death? ______
(Informant) ______	Former or usual residence ______
(ADDRESS) ______	PLACE OF BURIAL OR REMOVAL / DATE OF BURIAL ______, 191__
Filed ______, 191__, ______ REGISTRAR	UNDERTAKER / ADDRESS