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: Pettis

Township: ~~[illegible]~~ or Village: or City: Sedalia (No. 207 E Saline St.; Ward)

Registration District No. 668 — File No. 9547

Primary Registration District No. 3032 — Registered No. 81

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

FULL NAME Rebecca Jane Christopher

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female — COLOR OR RACE: White — ~~SINGLE~~ MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

DATE OF BIRTH: April (Month) 20th (Day), 1861 (Year)

AGE: 53 yrs. 8 mos. 27 ds. — If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: house wife
(b) General nature of industry, business, or establishment in which employed (or employer):

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

PARENTS
NAME OF FATHER: Jacob Vaughn Jr.
BIRTHPLACE OF FATHER (City or town, State or foreign country): Don't Know
MAIDEN NAME OF MOTHER: Sarah McCray
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Ruth Adkins

(ADDRESS): Sedalia

Filed Mar 18, 1914. A. B. Long, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: March (Month) 17th (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from March 17, 1914, to March 17, 1914, that I last saw her alive on March 17, 1914, and that death occurred, on the date stated above, at 8 p.m.

The CAUSE OF DEATH* was as follows: Pneumonia (Lobar)

108

(Duration) ___ yrs. ___ mos. 10 ds.

Contributory (Secondary): none

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

(Signed) W. O. Dunlap M. D.

March 18, 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: Brown Hill Cemetery — DATE OF BURIAL: March 18, 1914

UNDERTAKER: Durbaugh & Allen — ADDRESS: Sedalia Mo

PLACE OF DEATH

County.....

Township .....
or
Village.....
or
City .....(NO.....,.....St.:.....Ward)

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

Registration District No..... File No.....

Primary Registration District No..... Registered No.....

[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

.....(Month)....., *1*.....(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

.....(Month)....., *191*.....(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