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 Wayne Co

Township ~~Benton~~ or Village or City Piedmont (NO. ____, ____ St.; ____ Ward)

Registration District No. 891 File No. 11437

Primary Registration District No. 4540 Registered No. ____

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

FULL NAME Mary S. Munger

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: W.

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Widdow

DATE OF BIRTH: Dec. (Month) 23 (Day), 1832 (Year)

AGE: 81 yrs. 2 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): non

BIRTHPLACE (City or town, State or foreign country): Lesterville Reynolds Co. Mo

PARENTS
NAME OF FATHER: Marshel Parks
BIRTHPLACE OF FATHER (City or town, State or foreign country): George S
MAIDEN NAME OF MOTHER: Mary Hinchey
BIRTHPLACE OF MOTHER (City or town, State or foreign country): George

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. S. Munger

(ADDRESS) Dexter, Mo.

Filed Mch. 27, 1914. L. E. Toney REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Mch. (Month) 20 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Mch. 17, 1914, to Mch. 20, 1914, that I last saw her alive on Mch. 20, 1914, and that death occurred, on the date stated above, at 3.50 m.

The CAUSE OF DEATH* was as follows:

131 Eremic Coma.
139 B

(Duration) ____ yrs. ____ mos. 5 ds.

Contributory (SECONDARY) Bright's Disease

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

(Signed) L. E. Toney M. D.

Mch. 21, 1914 (Address) Piedmont.

*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~~: Dexter Mo

DATE OF BURIAL: March 21, 1914

UNDERTAKER: Chas S. Diesel

ADDRESS: Piedmont Mo.

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 _____

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.

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 _____, 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 _____, 191____
UNDERTAKER	ADDRESS