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 Montgomery

Township Bear Creek

or Village ~~High Hill~~

or City

Registration District No. 589 File No. 13272

Primary Registration District No. 5787 Registered No. 37

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

FULL NAME Eulah Day Best

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Married

DATE OF BIRTH Jan (Month) 6 (Day), 1895 (Year)

AGE 19 yrs. 4 mos. — ds. If LESS than 1 day, ... hrs. or ... min.?

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

BIRTHPLACE (City or town, State or foreign country) Mexico Mo

PARENTS

NAME OF FATHER John Geyler

BIRTHPLACE OF FATHER (City or town, State or foreign country) Montgomery County Mo

MAIDEN NAME OF MOTHER Mary Howard

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. J. C. Best

(ADDRESS) High Hill, Mo.

Filed Apr 6, 1914. J. M. Forman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mch (Month) 6 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 2, 1913, to Mch 2, 1914, that I last saw her alive on Feb 2, 1914, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) ... yrs. 6 mos. ... ds.

Contributory (Secondary) ...

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

(Signed) J. C. Best M. D.

Mch 6, 1914 (Address) Jonesburg 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	DATE OF BURIAL
Mt Pleasant	Mch 9, 1914
UNDERTAKER	**ADDRESS**
J. F. Snare	High Hill

PLACE OF DEATH

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

County.....

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

[If death occurr hospital or ins give its NAME of street and num

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

....., 1
(Month) (Day) (

I HEREBY CERTIFY, that I attended deceased

....., 191...., to....., 1

that I last saw h..... alive on....., 1

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).....

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

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIEI 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
UNDERTAKER	ADDRESS

Revised United States Standard Certificate