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: Pettie

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

Registration District No. 668 — File No. 23578

Primary Registration District No. 3032 — Registered No. 163

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

FULL NAME: Mary H Gibson

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: white

~~SINGLE~~ MARRIED ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word) married

DATE OF BIRTH: April (Month) 17 (Day), 1847 (Year)

AGE: 67 yrs. 2 mos. 26 ds. — If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: House Keeper 117 B
(b) General nature of industry, business, or establishment in which employed (or employer): 87 A

BIRTHPLACE (City or town, State or foreign country): Leesburgh Va.

PARENTS
NAME OF FATHER: J. G. Gregg.
BIRTHPLACE OF FATHER (City or town, State or foreign country): Leesburgh Va
MAIDEN NAME OF MOTHER: Martha A Shepherd
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Leesburgh Va

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): C. T. McConnell

(ADDRESS): Houstonia Mo

Filed July 13, 1914 — F. B. Long, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: July (Month) 12 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 1, 1914, to July 12, 1914, that I last saw her alive on July 12, 1914 and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Duodenal Ulcer

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

Contributory (SECONDARY): Multiple Neuritis

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

(Signed) E A Mook M. D.

July 13, 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: Crown Hill

DATE OF BURIAL: July 13, 1914

UNDERTAKER: McLaughlin

ADDRESS: Sedalia 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 .....

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

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 import