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 or Village or City: Sedalia (NO. ____ St.; ____ Ward)

Registration District No. 668 — File No. 17 23587

Primary Registration District No. 3032 — Registered No. ____

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

FULL NAME Rebeca Humphey

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH: 1 (Month) ____ (Day) 1824 (Year)

AGE: 90 yrs. ____ mos. ____ ds. — If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): 162

BIRTHPLACE (City or town, State or foreign country): England

PARENTS
- NAME OF FATHER: Harry Saunders
- BIRTHPLACE OF FATHER (City or town, State or foreign country): England
- MAIDEN NAME OF MOTHER: Sarah Wood
- BIRTHPLACE OF MOTHER (City or town, State or foreign country): England

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs L Q Slagle

(ADDRESS) Sedalia Mo

Filed 7/20, 1914 — H. B. Long, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: July (Month) 19 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from April 15, 1914 to July 15, 1914, that I last saw her alive on July 18, 1914 and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

No specific cause just gradually worn out 90 years old

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

Contributory (SECONDARY): Senility

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

(Signed) Frank R Minley M. D.

July 20 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 — DATE OF BURIAL: July 21, 1914

UNDERTAKER: McLaughlin Bros — ADDRESS: 575 Ohio St

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

[illegible] should be stated EXACTLY. PHYSICIANS should state [illegible] Exact statement of OCCUPATION is very import[illegible]