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

File No. 29817

PLACE OF DEATH

County: Monroe

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

Registration District No. 579

Primary Registration District No. 577619

Registered No.

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

FULL NAME Phillis Burgess.

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	Negro	widowed

DATE OF BIRTH: Don't Know (Month) (Day) (Year)

AGE: Don't Know. yrs. mos. ds. — If LESS than 1 day, hrs. or min.?

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

BIRTHPLACE (City or town, State or foreign country): Don't Know

PARENTS
NAME OF FATHER: Don't Know.
BIRTHPLACE OF FATHER (City or town, State or foreign country): Don't Know
MAIDEN NAME OF MOTHER: Don't Know.
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Don't Know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D. H. Hathman

(ADDRESS) Madison Mo.

Filed Sept 2, 1914. C. H. Eubank REGISTRAR

2

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Sept. (Month) 2nd (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 2nd, 1914, to Sept. 2nd, 1914, that I last saw her alive on Don't Know, 1914, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

82 A

(Duration) yrs. mos. ds.

Contributory (SECONDARY) age.

(Duration) yrs. mos. ds.

(Signed) M. A. Hensley M. D.

9/2, 1914 (Address) Madison 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
Holliday Mo	9-3 1914

UNDERTAKER	ADDRESS
L. E. Miller	Holliday Mo

N. B.—Every item
CAUSE OF DE

MANENT RECORD

ACTLY. PHYSICIANS should state
of OCCUPATION is very important.

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 inst give its NAME of street and nun

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

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

I HEREBY CERTIFY, that I attended decease

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

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

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 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