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 Shelby

Township Jackson

or

Village

or

City (NO. St.: Ward)

Registration District No. 628 File No. 34320

Primary Registration District No. 6090a Registered No. 9

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

FULL NAME Priscilla Brooks

PERSONAL AND STATISTICAL PARTICULARS

SEX Female

COLOR OR RACE white

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) widowed

DATE OF BIRTH Jan. 3, 1828 (Month) (Day) (Year)

AGE 86 yrs. 9 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) Ohio

PARENTS

NAME OF FATHER John Leach

BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio

MAIDEN NAME OF MOTHER Anna Reed

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. A. McWolf

(ADDRESS) Shelbina, Mo

Filed Oct 8, 1914. W. A. Hobson REGISTRAR

M.R.

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 5 (Month) 5 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Aug. 15, 1914, to Oct 5, 1914, that I last saw her alive on Oct 5, 1914, and that death occurred, on the date stated above, at 6 P.m.

The CAUSE OF DEATH* was as follows:

inanition of old age

Senility 154

162 (Duration) 1 yrs. — mos. — ds.

Contributory (SECONDARY) Old age

— (Duration) — yrs. — mos. — ds.

(Signed) W. T. Patterson M. D.

Oct 6, 1914 (Address) Shelbina 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. 3 mos. — ds. In the State 35 yrs. — mos. — ds.

Where was disease contracted if not at place of death? —

Former or usual residence Same.

PLACE OF BURIAL OR REMOVAL Benbow.

DATE OF BURIAL Oct 7, 1914

UNDERTAKER J. M. Thompson & Son.

ADDRESS Shelbyville, 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 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

..... (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

..... (Month) ..... (Day) ..... 191.. (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 .....

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, (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, 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
	..... 19..
UNDERTAKER	ADDRESS

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report