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~~ Pettis

Township or Village or City: ~~Cedar~~ Cedar

Registration District No. 671 — File No. 36 ~~39~~ A

Primary Registration District No. 5894 — Registered No. 4

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

FULL NAME: Oliver Elmore (Elmore)

PERSONAL AND STATISTICAL PARTICULARS

SEX: M — COLOR OR RACE: W — ~~SINGLE~~ MARRIED WIDOWED ~~OR DIVORCED~~ (Write the word): Widow

DATE OF BIRTH: Dec 3 (Month) / 1825 (Day) (Year)

AGE: 88 ~~89~~ yrs. 11 mos. 23 ds. — If LESS than 1 day, ____ hrs. or ____ min.?

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

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

PARENTS
NAME OF FATHER: Jno Elmore
BIRTHPLACE OF FATHER (City or town, State or foreign country): Ky
MAIDEN NAME OF MOTHER: Elizabeth Hawk
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): N Elmore (Son)

(ADDRESS): Sedalia Mo

Filed Nov 26, 1914. B. N. Harris, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Nov 24, 1914 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 15, 1914, to Nov. 24, 1914, that I last saw h. ~~in~~ alive on Nov 24, 1914 and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

10 TH
1 68

(Duration) ____ yrs. ____ mos. 9 ds.

Contributory (SECONDARY): General Debility

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

(Signed) J. E. Mitchell M. D.

Nov 24, 1914 (Address) Hughesville 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: Miller Chapel — DATE OF BURIAL: Nov 26, 1914

UNDERTAKER: W. Hall — ADDRESS: Sedalia Mo

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 import

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

..... (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), *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.....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