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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County: Schuyler

Township: ~~Salt River~~

or Village:

or City: Greentop Mo (NO. ____, ____ St.; ____ Ward)

Registration District No.: 804 File No.: 41070

Primary Registration District No.: 4483 Registered No.: ____

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

FULL NAME Mary F Owens

PERSONAL AND STATISTICAL PARTICULARS

SEX: female

COLOR OR RACE: white

~~SINGLE~~ MARRIED WIDOWED ~~OR DIVORCED~~ (Write the word): widow

DATE OF BIRTH: April (Month) 23 (Day), 1839 (Year)

AGE: 75 yrs. 8 mos. 23 ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE (City or town, State or foreign country): Virden Ill.

PARENTS

NAME OF FATHER: Hardy Gallin

BIRTHPLACE OF FATHER (City or town, State or foreign country): Ill. ~~Not known~~

MAIDEN NAME OF MOTHER: Katie Crawsford

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Millie E. Owens

(ADDRESS) Greentop Mo

Filed Dec. 15, 1914 F B Farrington REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Dec (Month) 15 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from For 2 yrs., 191__, to ____, 191__, that I last saw her alive on Dec 15, 1914, and that death occurred, on the date stated above, at 2 P.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

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

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

(Signed) F B Farrington M. D.

____, 191__ (Address) Greentop

*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: Greentop

DATE OF BURIAL: Dec. 18 1914

UNDERTAKER: L. A. Young

ADDRESS: Greentop 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

..... (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

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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