PLACE OF DEATH

County Atchison

Township Benton

or

Village

or

City (NO. St.; Ward)

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

Registration District No. 19 File No. 27-1

Primary Registration District No. 5024 Registered No.

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

FULL NAME Mary A Wade

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: April (Month) 29 (Day), 1890 (Year)

AGE: 25 yrs. 7 mos. 7 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife 140
(b) General nature of industry, business, or establishment in which employed (or employer): 129

BIRTHPLACE (City or town, State or foreign country): Atchison Co Mo.

PARENTS

NAME OF FATHER: Harmon H Eilers

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

MAIDEN NAME OF MOTHER: Katherine Bowers.

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Nemaha Co Neb.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roy Wade

(ADDRESS) Langdon Mo.

Filed Nov 6, 1927 Mary C. Chamberlain REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Dec 6 (Month) (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 1, 1915, to Dec 6, 1915, that I last saw her alive on Dec 6, 1915, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF ~~DEATH~~* was as follows:

peritonitis

146 (Duration) yrs. mos. ds.

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

(Signed) Chas. T. Heller M. D.

Dec 8, 1915 (Address) Rock Port 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: Hunter Cemetery

DATE OF BURIAL: Dec 8, 1915

UNDERTAKER: A E Hetmer

ADDRESS: Rock Port Mo

MISSOURI STATE BOARD OF HEAL
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 i hospital or institut give its NAME inst 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 fro

....., 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. .....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