

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 Waigne
Township Piedmont
or
Village Piedmont
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 891 File No. 3590
Primary Registration District No. 4540 Registered No. _____

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

FULL NAME

Naney Angel

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white SINGLE married
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH May 25, 1871
(Month) (Day) (Year)

AGE 43 yrs. 6 mos. 26 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE
(City or town, State or foreign country) Tennessee

PARENTS
NAME OF FATHER Jasper S. Freeman
BIRTHPLACE OF FATHER Tennessee
MAIDEN NAME OF MOTHER Sarah N. Gumm
BIRTHPLACE OF MOTHER Tennessee

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sarah N. Freeman
(ADDRESS) Piedmont, Mo.

Filed Jan 5, 1915 L. E. Toney
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 21, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 19, 1914, to Dec 21, 1914, that I last saw him alive on Dec 21, 1914, and that death occurred, on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Cancer insana of
uterus

48

(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 Patterson Mo. DATE OF BURIAL Dec 23, 1914

UNDERTAKER Chas. S. Alieel ADDRESS Piedmont

PLACE OF DEATH

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

County _____

Township _____
or _____Village _____
or _____

City _____

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

(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 (If file 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
business; or establishment in
which employed (or employer) _____(b) General nature of industry,
business; or establishment in
which employed (or employer) _____

BIRTHPLACE

(City or town,
State or foreign country)NAME OF
FATHERBIRTHPLACE
OF FATHER

(City or town, State or foreign country)

MOTHER'S NAME
OF MOTHERBIRTHPLACE
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 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) _____

(Address) _____

M. D. _____

*State the Disease Causing Death, or, in deaths from: Violent Cause, 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. 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

UNDERTAKER

ADDRESS

191____