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 Andrew

Township Prairie

or

Village

or

City (NO. 5033 St.; Ward)

Registration District No. 24 File No. 18197

Primary Registration District No. ~~4018~~ Registered No.

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

FULL NAME Judith E Lalley

PERSONAL AND STATISTICAL PARTICULARS

SEX Female

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widow

DATE OF BIRTH March (Month) 14 (Day), 1833 (Year)

AGE 82 yrs. 1 mos. 15 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 80 feet of Place birth

BIRTHPLACE (City or town, State or foreign country) Andrew County Mo

PARENTS

NAME OF FATHER George Lalley

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

MAIDEN NAME OF MOTHER Patsy Wilson

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Lalley

(ADDRESS) Laddonia Mo R F D

Filed June 1, 1915 T M Monroe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April (Month) 29 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from April 16, 1915, to April 27, 1915, that I last saw her alive on April 27, 1915, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

52

107A

91

(Duration) ___ yrs. ___ mos. 12 ds.

Contributory (SECONDARY) Cancer of the Face

(Duration) 3 yrs. — mos. — ds.

(Signed) John S Drake M. D.

April 30 1915 (Address) Santa Fe 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 Family Cem Adrian County Mo DATE OF BURIAL April 30 1915

UNDERTAKER Snyder & Hanger ADDRESS Santa Fe 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

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