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.

PLACE OF DEATH

County Pettis

Dr. Logan

Township or Village or City Sedalia (NO. General Hospital St.: Ward)

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

Registration District No. 668 File No. 22552

Primary Registration District No. 9032 Registered No. 185

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

FULL NAME Phoebe Ann Orcutt

PERSONAL AND STATISTICAL PARTICULARS

SEX F. COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widowed

DATE OF BIRTH July 18 (Month) (Day) 1841 (Year)

AGE 73 yrs. 11 mos. 22 ds. If LESS than 1 day, ... hrs. or ..... min.?

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

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

PARENTS
NAME OF FATHER Mr French
BIRTHPLACE OF FATHER (City or town, State or foreign country) U. S. A.
MAIDEN NAME OF MOTHER Dont know
BIRTHPLACE OF MOTHER (City or town, State or foreign country) " "

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. E. Orcutt

(ADDRESS) Sedalia Mo.

Filed July 12 1915 F. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 11 (Month) (Day) 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from April 10, 1915, to July 10, 1915, that I last saw her alive on July 10, 1915, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Senile debility.

82 II

162 154 (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY) Paralysis (Duration) — yrs. 3 mos. — ds.

(Signed) H. F. Logan M. D.

July 12 1915 (Address) Sedalia 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. 1 mos. 10 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? At her home

Former or usual residence 1420-8-Missouri

PLACE OF BURIAL OR REMOVAL Crown Hill

DATE OF BURIAL July 13 1915

UNDERTAKER McLaughlin Bros.

ADDRESS Sedalia, Mo

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.....

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