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

PLACE OF DEATH

County: Pike

Township or Village or City: Hartford ~~New Hartford~~

Registration District No. 690 File No. 10 22606

Primary Registration District No. 5918 Registered No. 10

(NO. ..... St.: ..... Ward)

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

FULL NAME Nellie Von McPike Parsons.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: Colored

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

DATE OF BIRTH: 12 (Month) 11 (Day), 1892 (Year)

AGE: 23 yrs. 6 mos. 6 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): Ashley. Mo.

PARENTS

NAME OF FATHER: John H. McPike

BIRTHPLACE OF FATHER (City or town, State or foreign country): Ashley. Mo.

MAIDEN NAME OF MOTHER: Anna Tizza Keith

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Hartford Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John H. McPike

(ADDRESS) Ashley Mo.

Filed July 17, 1915. R. G. Hreford REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: 7 (Month) 17 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from 7-16, 1915, to 7-17, 1915, that I last saw her alive on 7-16, 1915 and that death occurred, on the date stated above, at 6:15 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

23A

(Duration) ..... yrs. 4 mos. ..... ds.

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

(Signed) Ray S. Gay M.D. M. D.

7-17, 1915 (Address) New Hartford 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 5 yrs. 6 mos. ..... ds. In the State 23 yrs. 6 mos. 6 ds.

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

Former or usual residence: Ashley Mo.

PLACE OF BURIAL OR REMOVAL: Ashley Mo

DATE OF BURIAL: July 18, 1915

UNDERTAKER: None.

ADDRESS: —

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALT
BUREAU OF VITAL STATISTICS
CERTIFICATE 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 ... hospital or institu... give its NAME in ... of street and numbe...

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

....., 19...
(Month) (Day) (Y...

I HEREBY CERTIFY, that I attended deceased ..., 191..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at .....
The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs. .....mos.

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

(Signed).....

....., 191... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT RECENT RESIDENTS)

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos.

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
UNDERTAKER	ADDRESS

...clature of the American Medical Association.)

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report