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 Shelby

Township Black Hawk

or

Village

or

City (NO. St.; Ward)

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

Registration District No. 831 File No. 26613

Primary Registration District No. 6092 Registered No. 16

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

FULL NAME Mabel Gertrude Berkley

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Married

DATE OF BIRTH: Oct 8. (Month) (Day), 1873 (Year)

AGE: 42 yrs. 10 mos. 8 ds. If LESS than 1 day, hrs. or min.?

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

BIRTHPLACE (City or town, State or foreign country): Black Hawk Co. Iowa

PARENTS

NAME OF FATHER: S. Hollenbeck

BIRTHPLACE OF FATHER (City or town, State or foreign country): N. Y.

MAIDEN NAME OF MOTHER: Katherine Hallowell

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B. S. Berkley

(ADDRESS) Shelbyville, Mo.

Filed Aug 17, 1915 — Wm Carson, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: August (Month) 16 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from July 25, 1915, to Aug 16, 1915, that I last saw h[illegible] alive on Aug 16, 1915, and that death occurred, on the date stated above, at 9-15 a.m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(Duration) yrs. mos. 29 ds.

Contributory (SECONDARY) Abortion 2nd month

(Duration) yrs. mos. ds.

(Signed) C E Salyer, M.D.

Aug 16, 1915 (Address) Shelbyville

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: I.O.O.F. Cemetery — DATE OF BURIAL: Aug 18, 1915

UNDERTAKER: J. M. Thompson Son — ADDRESS: Shelbyville, Mo.

PLACE OF DEATH

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

Revised United States Standard

County.....

Township ..... Registration District No..... File No.....
or
Village..... Primary Registration District No..... Registered No.....
or
City ..... (NO. ..... St.; ..... Ward)

[If death occurr... hospital or insti... give its NAME ... of street and numb...

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX | COLOR OR RACE | SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* 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 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) (

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) ..... M...

....., 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, TRANSIENTS 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

UNDERTAKER

DATE OF BURIAL

....., 19...

ADDRESS