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

27008

PLACE OF DEATH

County Cape Girardeau

Township ~~Cape Girardeau~~ Registration District No. 125 File No.

or

Village Primary Registration District No. 3009 Registered No. 1234

or

City Cape Girardeau (No.) 415 N. Middle St.; 2 Ward)

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

FULL NAME Lizzie Abernathy

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Mar (Month) 1st (Day) 1876 (Year)

AGE 39 yrs. 6 mos. 9 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) Cape Girardeau Co

PARENTS

NAME OF FATHER John Johnson

BIRTHPLACE OF FATHER (City or town, State or foreign country) Tenn.

MAIDEN NAME OF MOTHER Pauline Venerable

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lawrence Abernathy

(ADDRESS) Cape Girardeau Mo

Filed Sept 12 1915 R. N. Fissell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept (Month) 10 (Day) 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from May 1, 1915, to Sept 10, 1915, that I last saw her alive on Sept 8, 1915, and that death occurred, on the date stated above, at 9:30 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

R3A

(Duration) 1 yrs. ____ mos. ____ ds.

Contributory (SECONDARY) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. E. Burns M. D.

191 (Address) 709 Broadway

*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 Fairmount Cemetery

DATE OF BURIAL Sept 12. 1915

UNDERTAKER Walther F & M Co

ADDRESS Cape Girardeau Mo

PLACE OF DEATH

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

Registered Illness

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

..... (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

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

I HEREBY CERTIFY, that I attended deceased f
....., 191..., to ....., 191.
that I last saw h..... alive on ....., 191.
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, st (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	DATE OF BURIAL
	....., 191
UNDERTAKER	**ADDRESS**