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 Shelby

Township or Village Shelbyville or City (NO. St.; Ward)

Registration District No. 831 File No. 29541

Primary Registration District No. 4504 Registered No. 22

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

FULL NAME Sarah Messick Craigmyle

PERSONAL AND STATISTICAL PARTICULARS

SEX Female

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widowed

DATE OF BIRTH Aug 16 (Month) (Day) 1832 (Year)

AGE 83 yrs. 1 mos. 12 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) Worchester Co. Md.

PARENTS

NAME OF FATHER Soloman Evans

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

MAIDEN NAME OF MOTHER Jennie Dingle

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Fred Boettcher

(ADDRESS) Shelbyville, Mo.

Filed Sept 29, 1915 Wm Carson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept (Month) 28 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from June 1, 1915, to Sept 28, 1915, that I last saw her alive on Sept 27, 1915, and that death occurred, on the date stated above, at 11:08 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy Cerebral 45

46C

82A

(Duration) X yrs. X mos. 14 ds.

Contributory (SECONDARY) Carcinoma of bowel

(Duration) yrs. 6 mos. X ds.

(Signed) P. C. Archer M. D.

Sept 29, 1915 (Address) Shelbyville 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 Oak Dale Cemetery

DATE OF BURIAL Sept. 30, 1915

UNDERTAKER J. W. Thompson Son

ADDRESS Shelbyville, Mo

MISSOURI STATE BOARD OF HEAL
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 hospital or instit give its NAME fr 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

....., 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 ....., 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) .....

....., 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 ....., 19
UNDERTAKER	ADDRESS

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