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 Montgomery

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

Registration District No. 592 File No. 34315

Primary Registration District No. 4350 Registered No. 29

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

FULL NAME Margrette Mallerson

PERSONAL AND STATISTICAL PARTICULARS

SEX F

COLOR OR RACE W

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) widowed

DATE OF BIRTH Aug (Month) 26 (Day) 1833 (Year)

AGE 80 yrs. 2 mos. 26 ds. If LESS than 1 day, ... hrs. or ..... min.?

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

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

PARENTS
NAME OF FATHER James A McClure
BIRTHPLACE OF FATHER (City or town, State or foreign country) Virginia
MAIDEN NAME OF MOTHER Miss Glasford
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Virginia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. N. Mallerson

(ADDRESS) Montgomery Mo

Filed 11/23 1915 E. W. Linsley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 11 (Month) 22 (Day) 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from May 23, 1913, to Nov. 22nd, 1915, that I last saw her alive on Nov. 22nd, 1915, and that death occurred, on the date stated above, at 11 Am 30 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

131
132 Uraemia — 120

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

Contributory (SECONDARY) .....

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

(Signed) David Nowlin M. D.

Nov. 23 1915 (Address) Montgomery City, 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 Montgomery City Cemetery

DATE OF BURIAL 11/23 1915

UNDERTAKER C. W. Hopkins

ADDRESS Montgomery Mo

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

..... , 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

..... , 191.....
(Month) (Day) (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

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.