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 Montgomery

or

Village

or

City (NO. St.; Ward)

Registration District No. 592

Primary Registration District No. 5790

File No. 38096

Registered No. 35

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

FULL NAME Kathryn White

PERSONAL AND STATISTICAL PARTICULARS

SEX F

COLOR OR RACE W

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) married

DATE OF BIRTH Jan (Month) 22 (Day), 1883 (Year)

AGE 92 yrs. 11 mos. 2 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country) Callaway Co Mo

PARENTS

NAME OF FATHER M. Covington

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

MAIDEN NAME OF MOTHER Kathryn Suddith

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Robt Dickerson

(ADDRESS) Montgomery City Mo

Filed 12/30 1915 E.W. Tinsley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from Dec. 21, 1915, to Dec. 28, 1915, that I last saw her alive on Dec. 27, 1915, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

108
169

(Duration) ___ yrs. ___ mos. 8 ds.

Contributory (SECONDARY) Senility

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

(Signed) G. E. Muns, M. D.

Dec. 28, 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 Cemetery

DATE OF BURIAL 12/30 1915

UNDERTAKER C W Hopkins

ADDRESS Montgomery Mo

PLACE OF DEATH

County _____

Township _____
or
Village _____
or
City _____ (NO. _____ _____ St.: _____ Ward)

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

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

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

FULL NAME _____

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.

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