

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 Pettis
Township Hester Creek or Village _____ or City _____
Registration District No. 673 File No. 38298
Primary Registration District No. 5896 Registered No. _____
(NO. _____) (St. _____) (Ward _____)
(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Bermelia Arrie Jewitt

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED married WIDOWED OR DIVORCED (If write the word)

DATE OF BIRTH August 6, 1890
(Month) (Day) (Year)

AGE 85 yrs. 4 mos. 14 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) Missouri

PARENTS
NAME OF FATHER John Potter
BIRTHPLACE OF FATHER Missouri
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Patsy Edgar
BIRTHPLACE OF MOTHER Ky
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joe Jewitt
(ADDRESS) Beaman Mo

Filed Dec 21, 1915 E. H. Leftwich
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 20, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 8, 1915, to Dec 17, 1915, that I last saw her alive on Dec 17, 1915, and that death occurred, on the date stated above, at 10 m. The CAUSE OF DEATH* was as follows:
Broncho Pneumonia

(Duration) ___ yrs. ___ mos. ___ ds.
Contributory Semility
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) J. S. Parrish M. D.
Dec 21, 1915 (Address) Phosout Green 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 Patter DATE OF BURIAL Dec 21, 1915

UNDERTAKER Mc Laughlin ADDRESS Adalia

PLACE OF DEATH

County _____

Township _____

or

Village _____

or

City _____

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

(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 (If file the word)
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DATE OF BIRTH

(Month) _____ (Day) _____ (Year) _____

AGE

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) _____

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

(Month) _____ (Day) _____ (Year) 191 _____

I HEREBY CERTIFY, that I attended deceased from _____, 191 _____, to _____, 191 _____, that I last saw him 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. _____

(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. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death?

Former or usual residence _____

(Informant) _____

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191 _____

UNDERTAKER

ADDRESS