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 Montgomery
or
Village
or
City (NO. St.: Ward)

Registration District No. 592 File No. 2552

Primary Registration District No. 5790 Registered No. 2

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

FULL NAME Alice Lutch

PERSONAL AND STATISTICAL PARTICULARS

SEX F

COLOR OR RACE W

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

DATE OF BIRTH Unknown, 875 (Month) (Day) (Year)

AGE 61 yrs. mos. 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) St Louis Mo

PARENTS

NAME OF FATHER Mr Shannon

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

MAIDEN NAME OF MOTHER Dont Know

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. G. Lutch

(ADDRESS) Montgomery City Mo

Filed 1/15 1916 E. W. Linsley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan. 13, 1916 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 12, 1916, to Jan 18, 1916, that I last saw her alive on Jan 12, 1916, and that death occurred, on the date stated above, at 8 45 a m.

The CAUSE OF DEATH* was as follows:

82A Apoplexy

64

(Duration) yrs. mos. 1 ds.

Contributory (Secondary) Age — previous apoplectic Seizure (Duration) 10 yrs. mos. ds.

Age? (Signed) G. F. Mims M. D.

8 1/15/1916 (Address) Montgomery

*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 St Marys Cemetery

DATE OF BURIAL 1/15 1916

UNDERTAKER C. W. Hopkins

ADDRESS Montgomery Mo

PLACE OF DEATH

County Cas

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

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

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

[If death oc
hospital or
give its NA
of street and

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

..... (Month) ..... (Day)

I HEREBY CERTIFY, that I attended decea

....., 191....., to .....

that I last saw h..... alive on .....

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 (
(1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRA
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 BUR
UNDERTAKER	ADDRESS

Statement of cause of death.—Name, first, 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"); *Diphteria* (avoid use of "Croup"); *Typhoid fever* (never report

tions on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)