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

7324

PLACE OF DEATH

County Montgomery

Township Prairie

or Village ✓

or City ✓ (NO. ____ St.; ____ Ward)

Registration District No. 591 File No. ____

Primary Registration District No. 5789 Registered No. 4

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

FULL NAME Mary Ann Morris

PERSONAL AND STATISTICAL PARTICULARS

SEX Female

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widow

DATE OF BIRTH May (Month) 20 (Day), 1843 (Year)

AGE 72 yrs. 7 mos. 23 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) as above

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

PARENTS

NAME OF FATHER Isaac Stipp

BIRTHPLACE OF FATHER (City or town, State or foreign country) Not Known

MAIDEN NAME OF MOTHER Rachel Dennis

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J E Morris

(ADDRESS) Bell Flower Mo R F D 1H

Filed Feb-12th 1916 H. W. Ford REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH January (Month) 13 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from December 28, 1915, to Jan 13, 1916, that I last saw her alive on Jan 9, 1916, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

28

Tuberculosis Pulmonalis

23 A

1 ✓ (Duration) 1 yrs. ✓ mos. ✓ ds.

Contributory (SECONDARY) her great aye

(Duration) ✓ yrs. ✓ mos. ✓ ds.

(Signed) C F Elkins M. D.

1-13- 1916 (Address) Gamma 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 Brush Creek Cem

DATE OF BURIAL Jan 14, 1916

UNDERTAKER Chas. S. Murphy

ADDRESS Bellflower 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

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.