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: Shelby

Township or Village or City: Shelbyville (NO. ____ St.: ____ Ward)

Registration District No. 831 — File No. 13117

Primary Registration District No. 4504 — Registered No. 9

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

FULL NAME: Zeta Muldrow Garrison

**PERSONAL AND STATISTICAL PARTICULARS**

SEX: Female

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): married

DATE OF BIRTH: Nov. 8, 1879 (Month) (Day) (Year)

AGE: 36 yrs. 4 mos. 21 ds. — If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country): Shelby Co. Mo.

PARENTS

NAME OF FATHER: A. W. Muldrow

BIRTHPLACE OF FATHER (City or town, State or foreign country): Ralls Co. Mo.

MAIDEN NAME OF MOTHER: Belle McMurray

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Shelby Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. E. Garrison

(ADDRESS) Shelbyville, Mo.

Filed 3-30-1916 Wm Carson REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH: Mar. 29, 1916 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mch. 20, 1916, to Mch. 29, 1916, that I last saw her alive on March 29, 1916, and that death occurred, on the date stated above, at 11-20 a.m.

The CAUSE OF DEATH* was as follows:

Pleura Pneumonia

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

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

(Signed) ___ M. D.

Mch 30, 1916 (Address) C. E. Salyer

*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: Shelbyville - I.O.O.F.

DATE OF BURIAL: Mar 31, 1916

UNDERTAKER: J. W. Thompson Son

ADDRESS: Shelbyville, Mo.

Revised United States Standard
Certificate of Death

# MISSOURI STATE BOARD OF
## BUREAU OF VITAL STATIS
### 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 de hospita give it of stree

**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) (D

I HEREBY CERTIFY, that I attended d _____, 191__, to _____

that I last saw h _____ alive on _____

and that death occurred, on the date stated above,

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mo

Contributory _____
(SECONDARY)

_____ (Duration) _____ yrs. _____ mo

(Signed) _____

_____, 191__ (Address) _____

*State the Disease Causing Death, or, in deaths from Viole (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicid

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, T RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____

Where was disease contracted if not at place of death? _____

Former or usual residence _____

| PLACE OF BURIAL OR REMOVAL | DATE OF |
|---|---|
| UNDERTAKER | ADDRESS |