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: Vernon

Township: ____ or Village: Moundville, Mo or City: ____ (NO. ____ St.; ____ Ward)

Registration District No. 874 — File No. 13249

Primary Registration District No. 4528 — Registered No. ____

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

**FULL NAME** Cordelia M. Rimmer

**PERSONAL AND STATISTICAL PARTICULARS**

| SEX | COLOR OR RACE | SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) |
|---|---|---|
| Female | White | Widow |

DATE OF BIRTH: May (Month) ____ (Day), 1866 (Year)

AGE: 49 yrs. 10 mos. ____ ds. — If LESS than 1 day, ____ hrs. or ____ min.?

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

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

PARENTS
NAME OF FATHER: James H. Cox
BIRTHPLACE OF FATHER (City or town, State or foreign country): Tenn
MAIDEN NAME OF MOTHER: Matilda Coffelt
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) O. P. Cox

(ADDRESS) Moundville, Mo.

Filed ~~Apr 1~~ Mar 10, 1916. O. P. Fairrington, REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH: March (Month) 9 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from ____, 191__, to ____, 191__, that I last saw h____ alive on Mch 9th, 1916, and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis
11A
1066

89

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY) "Grippe"

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) O. P. Fairrington M. D.

191__ (Address) Moundville

*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: Walborn Cem. — DATE OF BURIAL: Mch. 10, 1916

UNDERTAKER: Jno. Donaldson — ADDRESS: Moundville, Mo.

# MISSOURI STATE BOARD
## BUREAU OF VITAL STAT
### CERTIFICATE OF DEAT

**PLACE OF DEATH**

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ..... St.; ..... Ward)

**FULL NAME** .....

**PERSONAL AND STATISTICAL PARTICULARS**

| SEX | COLOR OR RACE | SINGLE<br>MARRIED<br>WIDOWED<br>OR DIVORCED<br>(*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 DEAT**

DATE OF DEATH

..... (Month)

I HEREBY CERTIFY, that I attend

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

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

and that death occurred, on the date stated at

The CAUSE OF DEATH* was as follows:

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..... (Duration) ..... yrs. .....

Contributory
(SECONDARY)
..... (Duration) ..... yrs. .....

(Signed) .....

....., 191..... (Address) .....

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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 O

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