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 Gentry

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

Registration District No. 310 File No. 47576

Primary Registration District No. 4186 Registered No.

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

FULL NAME Malinda Pike-Hartman

PERSONAL AND STATISTICAL PARTICULARS

SEX Fmd

COLOR OR RACE Cau

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

DATE OF BIRTH Dec (Month) 18 (Day), 1824 (Year)

AGE 91 yrs. 2 mos. 6 ds. If LESS than 1 day, hrs. or min.?

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

BIRTHPLACE (City or town, State or foreign country) Putman Co Ind

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) Jas Pike

(ADDRESS) Darlington Mo

Filed May 25, 1916 R E Shelby REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feby (Month) 24 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 10, 1916, to Febry 24, 1916, that I last saw her alive on Febry 24, 1916, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia Bronchial

1078

91

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) A. L. Woolis M. D.

Mch 10, 1916 (Address) Darlington 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 Pike Cem

DATE OF BURIAL Feby 25 1916

UNDERTAKER H A Miller

ADDRESS Darlington

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 hosp give of st

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., I.....
(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

.....
(Month)

I HEREBY CERTIFY, that I attended

....., 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. .....m

Contributory .....
(SECONDARY)

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

(Signed) .....

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

*State the Disease Causing Death, or, in deaths from Vio (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homici

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, 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