MARGIN RESERVED FOR BINDING

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: Pettis

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

Registration District No. 468 — 4 — File No. 18778

Primary Registration District No. 3032 — Registered No. 146

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

FULL NAME Mrs Nora Mulcahy

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: white

SINGLE / MARRIED / WIDOWED / OR DIVORCED (Write the word): Widowed

DATE OF BIRTH: Unknown (Month) (Day) 1851 (Year)

AGE: 65 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): Ireland

PARENTS
NAME OF FATHER: P. McAuliffe
BIRTHPLACE OF FATHER (City or town, State or foreign country): Ireland
MAIDEN NAME OF MOTHER: Dungan
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ireland.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) P T Mulcahy

(ADDRESS) Sedalia

Filed May 18, 1916 — A. B. Pace, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: May (Month) 17 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Apr 23, 1916, to May 17, 1916, that I last saw her alive on May 17, 1916, and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

1. Cerebral Haemorrhage
2. _____ (Duration) ____ yrs. ____ mos. 25 ds.

Contributory (SECONDARY): Cerebral Haemorrhage (Duration) ____ yrs. ____ mos. 25 ds.

(Signed) C. W. Tyler M.D.

May 18, 1916 (Address) Sedalia 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: Catholic Cem.

DATE OF BURIAL: May 19, 1916

UNDERTAKER: McLaughlin Bros.

ADDRESS: Sedalia Mo

Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *House-*

Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "*Asthenia*," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-

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 MARRIED WIDOWED OR DIVORCED (*Write the word*)

DATE OF BIRTH ..... (Month) ..... (Day) ....., I..... (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 DE

DATE OF DEATH ..... (Month)

I HEREBY CERTIFY, that I atte ....., 191....., to..... that I last saw h..... alive on..... and that death occurred, on the date stated The CAUSE OF DEATH* was as follows:

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

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

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

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTI 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

UNDERTAKER | ADDR