Dr albers

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. 668 — File No. 18779

Primary Registration District No. 3032 — Registered No. 148

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

FULL NAME Annie E. Burriss

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

DATE OF BIRTH: March (Month) 5 (Day), 1850 (Year)

AGE: 66 yrs. 2 mos. 14 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): Zanesville Ohio

PARENTS
NAME OF FATHER: George Murray
BIRTHPLACE OF FATHER (City or town, State or foreign country): U. S. A.
MAIDEN NAME OF MOTHER: Mary Sechler
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Canton Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jennie Moreman

(ADDRESS) Sedalia, Mo.

Filed May 20, 1916. H. B. Poe, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: May (Month) 20 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from March 1, 1915, to May 20, 1916, that I last saw her alive on May 19, 1916, and that death occurred, on the date stated above, at 4 A.m.

The CAUSE OF DEATH* was as follows:

Cancer Uterine.

48 hrs

(Duration) 2 yrs. — mos. — ds.

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

(Signed) Edw A Albers M. D.

May 20 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: Crown Hill Cemetery — DATE OF BURIAL: May 21 1916

UNDERTAKER: McLaughlin Bros — ADDRESS: Sedalia Mo

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.

PLACE OF DEATH

County .....

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

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

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

FULL NAME .....

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.

THIS IS A LEGAL DOCUMENT, WITH CONTRADING INK—THIS IS A PERMANENT RECORD

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