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

PLACE OF DEATH

County Knox

Township ~~Center~~

or

Village

or

City Edina (NO. ____ St.: ____ Ward)

Registration District No. 441 File No. 21743

Primary Registration District No. 4459 Registered No. 19

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

FULL NAME Albert G. Bostick

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	~~SINGLE~~ ~~MARRIED~~ WIDOWED ~~OR DIVORCED~~ (Write the word)
Male	White	

DATE OF BIRTH May (Month) 29 (Day) 1841 (Year)

AGE 74 yrs. 11 mos. 21 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): ____

BIRTHPLACE (City or town, State or foreign country): Yazoo City Miss

PARENTS

NAME OF FATHER: Absolumn Bostick

BIRTHPLACE OF FATHER (City or town, State or foreign country): Mississippi

MAIDEN NAME OF MOTHER: Mary G. Patton

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Mississippi

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry O Bostick

(ADDRESS) Edina Mo.

Filed June 10. 1916. H J Jurgens REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May (Month) 18th (Day) 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Aug, 1915, to May 18, 1916, that I last saw h in alive on May 18, 1916, and that death occurred, on the date stated above, at 1200 m.

The CAUSE OF DEATH* was as follows:

Diabetis

59

(Duration) ____ yrs. 10 mos. ____ ds.

Contributory (SECONDARY)

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

(Signed) W. J. Morris M. D.

May 19 1916 (Address) Edina 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	DATE OF BURIAL
Lincoln Cem	May 20 1916
UNDERTAKER	**ADDRESS**
Mudd & James	Edina Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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PLACE OF DEATH

County.....

Township.....
or
Village.....
or
City.....

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

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

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

(NO..... .....St.;.....Ward)

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

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

.....(Month) .....(Day) *19*..(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 .....

The CAUSE OF DEATH* was as follows:

.....

.....

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

Contributory.....
(SECONDARY)

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

(Signed)..... M.D.

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

*State the Disease Causing Death, or, in deaths from Violent Causes, (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

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

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

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

The [illegible] may be [illegible] under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

fact may be indicated thus: *Farmer (retired, 6 yrs.)*
For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING D[illegible] affection [illegible] ways the