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. R.F.D. St.; ..... Ward)

Registration District No. 668 File No. M 22196 183

Primary Registration District No. 3032 Registered No. 183

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

FULL NAME Mary Ann Stevens

PERSONAL AND STATISTICAL PARTICULARS

SEX F | COLOR OR RACE W | SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

DATE OF BIRTH Oct. 28, 1916 (Month) (Day) (Year)

AGE 60 yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or ..... min.?

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

BIRTHPLACE (City or town, State or foreign country) Ohio

PARENTS
NAME OF FATHER John Adams
BIRTHPLACE OF FATHER (City or town, State or foreign country) Mr. Known
MAIDEN NAME OF MOTHER Ann Sykes
BIRTHPLACE OF MOTHER (City or town, State or foreign country) " "

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C R Stevens

(ADDRESS) Sedalia Mo

Filed June 29 1916 F. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 29, 1916 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 26, 1916, to June 29, 1916, that I last saw her alive on June 28, 1916, and that death occurred, on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

131

170

(Duration) 10 yrs. 3 mos. — ds.

Contributory (SECONDARY) none

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

(Signed) Chas. Arnold M. D.

June 29, 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 Sedalia Mo | DATE OF BURIAL June 30, 1916

UNDERTAKER McLaughlin | ADDRESS Bro. Sedalia

PLACE OF DEATH

County.....

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

or

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

or

City ..... (NO. ....., ... St.; ..... Ward)

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

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

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

..... (Month) ....., 1..... (Year) (Day)

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

N. B.—Every item of information must be given. Write plainly. Be exact. Avoid abbreviations. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. VIOLENT DEATHS state MEANS OF INJURY and qualify whether accidental, suicidal or homicidal. For deaths who have been under a physician, state whether death was due to disease or to surgical operation was undertaken. For women state whether as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*.