

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 Pettis
 Township _____
 or
 Village _____
 or
 City Sedalia (NO. _____ St. _____ Ward _____)

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

Registration District No. 668 File No. 25371
 Primary Registration District No. 3832 Registered No. 200

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

FULL NAME Julia A Allen

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE, MARRIED, WIDOWED OR DIVORCED (If write the word) Widowed

DATE OF BIRTH Jan 14, 1837
 (Month) (Day) (Year)

AGE 79 yrs. 6 mos. 2 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) Pittsburg Pa.

PARENTS
 NAME OF FATHER John Woodruff
 BIRTHPLACE OF FATHER (City or town, State or foreign country) England
 MAIDEN NAME OF MOTHER Unknown
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. M. Harbough

(ADDRESS) Sedalia Mo.

Filed July 1, 1916 H. B. Jones

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 16, 1916
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 1, 1916, to July 16, 1916, that I last saw her alive on July 15, 1916, and that death occurred, on the date stated above, at 10⁰⁰ A.M.

The CAUSE OF DEATH* was as follows:

Illia Colitis
105
 (Duration) ____ yrs. ____ mos. 16 ds.

Contributory (SECONDARY) Age
 (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) E. A. Wood M. D.
July 17, 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 July 18, 1916

UNDERTAKER Sedalia Undert & Bur Co ADDRESS Sedalia Mo.

PLACE OF DEATH

County.....

Township.....

or

Village.....

or

City..... (NO.....)

Registration District No.

File No.

Primary Registration District No.

Registered No.

St.

Ward)

[If death occurred in a
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 (If write the word)
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DATE OF BIRTH

....., 191....., 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) NAME OF
FATHERBIRTHPLACE
OF FATHER

(City or town, State or foreign country)

MAIDEN NAME
OF MOTHERBIRTHPLACE
OF MOTHER

(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

191.....

REGISTRAR

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

Registration District No.

File No.

Primary Registration District No.

Registered No.

St.

Ward)

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 191....., 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)

..... 191.....

M. D.

*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 yrs. mos. ds. State yrs. mos. ds.
of death In the
Where was disease contracted
if not at place of death?Former or
usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

191.....