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 Lawrence

Township [illegible]

or

Village

or

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

Registration District No. 471 File No. 28411

Primary Registration District No. 6284 Registered No. 119

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

FULL NAME Lillie Brigance

PERSONAL AND STATISTICAL PARTICULARS

SEX Fem

COLOR OR RACE Wh.

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Mar.

DATE OF BIRTH April 30, 1862 (Month) (Day) (Year)

AGE 54 yrs. 3 mos. 29 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Housewife 431

(b) General nature of industry, business, or establishment in which employed (or employer) 951

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

PARENTS

NAME OF FATHER H Ramsey

BIRTHPLACE OF FATHER (City or town, State or foreign country) Don't Know

MAIDEN NAME OF MOTHER Don't Know

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Don't Know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Brigance

(ADDRESS) Pierce City, Mo

Filed Aug 30, 1916 J E Bauchner REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug. 29, 1916 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June, 1904, to Aug 29, 1916, that I last saw her alive on Aug 29, 1916, and that death occurred, on the date stated above, at 7:30 m.

The CAUSE OF DEATH* was as follows: 79

Mitral insufficiency due to chronic dilatation.

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

Contributory (SECONDARY) Chronic Bronchial Asthma Since Childhood. Chronic Interstitial Nephritis.

(Duration) 2 yrs. ___ mos. ___ ds.

(Signed) H Ross Clark M. D.

8-29-16, 191__ (Address) Pierce City, 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 Pierce City Mo

DATE OF BURIAL Aug 30, 1916

UNDERTAKER John Seufert

ADDRESS Pierce City 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.

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

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]

FULL NAME .....

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