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. ____ St.; ____ Ward)

Registration District No. 668 File No. 28810

Primary Registration District No. 3032 Registered No. 232

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

FULL NAME Elizabeth Francis Smith

PERSONAL AND STATISTICAL PARTICULARS

SEX: female

COLOR OR RACE: white

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): widow

DATE OF BIRTH: Dec - 19 (Month) (Day), 1859 (Year)

AGE: 56 yrs. 8 mos. ____ ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): —

BIRTHPLACE (City or town, State or foreign country): Missouri

PARENTS
NAME OF FATHER: B. H. Igo Sr.
BIRTHPLACE OF FATHER (City or town, State or foreign country): Kentucky
MAIDEN NAME OF MOTHER: Armilda Moore
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Missouri

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Geo W. Parker

(ADDRESS) San Rafael. Cal.

Filed Aug 21 1916. F. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from Jany 1, 1916, to Aug 20, 1916, that I last saw her alive on Aug 20, 1916, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

1 Interstitial Nephritis

120 Don't Know (Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY) Arteria Sclerosis (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) A E Monroe M. D.

Aug 21 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: Otterville Mo

DATE OF BURIAL: Aug 21 1916

UNDERTAKER: McLaughlin

ADDRESS: Sedalia

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**