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

PLACE OF DEATH

County: Shelby

Township or Village or City: Black Creek

Registration District No.: 831 — File No.: 30164

Primary Registration District No.: ~~4504~~ 6097 — Registered No.: 18

(NO. ____ St.; ____ Ward)

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

FULL NAME Mrs. Julia Parsons

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): widowed

DATE OF BIRTH: not known (Month) (Day), 1852 (Year)

AGE: 64 yrs. — mos. — ds.

If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): —

BIRTHPLACE (City or town, State or foreign country): Macon Co. Mo

PARENTS

NAME OF FATHER: Cook,

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

MAIDEN NAME OF MOTHER: Not known

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Not Known

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. E. Nelson

(ADDRESS) Atlanta, Mo.

Filed Aug 19, 1916 Wm Carson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: August (Month) 18 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from I saw her 2 times 6 months ago, that I last saw her alive on date above stated, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Valvular Insufficiency

92A

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

Contributory (SECONDARY) Chronic asthma

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

(Signed) C E Salyer M. D.

Aug 19, 1916 (Address) Shelbyville 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) Shelby Co Infirmary

At place of death 1 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: Leonard, Mo.

DATE OF BURIAL: Aug. 19, 1916

UNDERTAKER: J. W. Thompson Son

ADDRESS: Shelbyville, Mo.

Approved by U. S. Census and American Public Health Association.]

PLACE OF DEATH

County .....

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

or

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

or

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

MISSOURI STATE BOARD OF
BUREAU OF VITAL STATIS
CERTIFICATE OF DEATH

191

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 .....
(Month)

I HEREBY CERTIFY, that I attended .....

..... , 191..... , to .....

that I last saw h..... alive on .....

and that death occurred, on the date stated above .....

The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration) ..... yrs. ..... m

Contributory .....
(SECONDARY)

..... (Duration) ..... yrs. ..... m

(Signed) .....

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

*State the Disease Causing Death, or, in deaths from Violen
(1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicida

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

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

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BU
UNDERTAKER	ADDRESS