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 Vernon

Township Deerfield
or
Village
or
City (NO. St.; Ward)

Registration District No. 874 File No. 30234

Primary Registration District No. 6152 Registered No.

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

FULL NAME Sarah A Reynolds

PERSONAL AND STATISTICAL PARTICULARS

SEX: female

COLOR OR RACE: white

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

DATE OF BIRTH: Aug (Month) 30 (Day), 1840 (Year)

AGE: 75 yrs. 10 mos. 5 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

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

PARENTS
NAME OF FATHER: Don't know
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) Ellis Wilson

(ADDRESS) Moundville Mo

Filed Aug 1, 1916 O P Farrington REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: July (Month) 30 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from July 25, 1916, to July 30, 1916, that I last saw her alive on 25, 1916, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease

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

Contributory (SECONDARY) Insane for years (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) O P Farrington M. D.

7/30, 1916 (Address) Moundville 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: Wilburn Cem

DATE OF BURIAL: July 31 1916

UNDERTAKER: John Donaldson

ADDRESS: Mdville

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health

MISSOURI STATE BOARD OF H
BUREAU OF VITAL STATISTI
CERTIFICATE OF DEATH

PLACE OF DEATH

County .....

Township ..... or Village Mandeville or City .....

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

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

(NO. ..... St.: ..... Ward) [If dea hospital give its of street

FULL NAME James M. Hendricks

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	M

DATE OF BIRTH May 13 (Month) (Day) 1839 (Year)

AGE 77 yrs. ..... mos. 3 ds. If LESS than 1 day, ... hrs. or ..... min.?

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

BIRTHPLACE (City or town, State or foreign country) Pike Co. Ill

PARENTS
NAME OF FATHER Shelton Hendricks
BIRTHPLACE OF FATHER (City or town, State or foreign country) Kentucky
MAIDEN NAME OF MOTHER Rachel Madison
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ill

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Grace Whitworth

(ADDRESS) Mandeville Mo.

Filed ....., 191.... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH .....
(Month) (D

I HEREBY CERTIFY, that I attended de
....., 191...., to .....
that I last saw h..... alive on .....
and that death occurred, on the date stated above, a
The CAUSE OF DEATH* was as follows:

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

Contributory (SECONDARY) .....
.....(Duration).....yrs.....mo

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

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

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 B
UNDERTAKER	ADDRESS

Photocopy of a photostatic copy of the original. Not to be reproduced or distributed without permission.