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

36692

PLACE OF DEATH

County Andrain

Township Prairie

or

Village

or

City (NO. St.; Ward)

Registration District No. 24

Primary Registration District No. 5033

File No.

Registered No.

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

FULL NAME T S Daugherty

PERSONAL AND STATISTICAL PARTICULARS

SEX: male

COLOR OR RACE: White

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

DATE OF BIRTH: April (Month) 2 (Day), 1838 (Year)

AGE: 78 yrs. 7 mos. 0 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): Farming

BIRTHPLACE (City or town, State or foreign country): Ky.

PARENTS

NAME OF FATHER: Thomas Daugherty

BIRTHPLACE OF FATHER (City or town, State or foreign country): Bracken Co, Ky.

MAIDEN NAME OF MOTHER: Do not Know

BIRTHPLACE OF MOTHER (City or town, State or foreign country): — —

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Oaks

(ADDRESS) Wellsville Mo.

Filed Nov 1st, 1916. T M Monroe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Nov (Month) 2 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Feb, 1916, to Nov, 1916, that I last saw him alive on Nov 1 —, 1916, and that death occurred, on the date stated above, at ___ m.

The CAUSE OF DEATH* was as follows:

Enlargement of Prostate gland

137

124 1353 (Duration) 1 yrs. ___ mos. ___ ds.

Contributory (SECONDARY) cystitis

(Duration) ___ yrs. 3 mos. ___ ds.

8 (Signed) W. K. McCall M. D.

Nov 3 1916 (Address) Laddonia

*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: Farber Mo

DATE OF BURIAL: Nov 3 1916

UNDERTAKER: H. G. Grainger

ADDRESS: Laddonia Mo.

PLACE OF DEATH

County _____

Township _____ or Village _____ or City _____ (NO. _____ St.: _____ Ward)

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

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurred i hospital or institut give its NAME inst 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 _____ (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) _____ (Day) _____, 191__ (Yea

I HEREBY CERTIFY, that I attended deceased fr _____, 191__, to _____, 191__ that I last saw h _____ alive on _____, 191__ and that death occurred, on the date stated above, at _____ r

The CAUSE OF DEATH* was as follows:

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ d

Contributory (SECONDARY) _____

_____ (Duration) _____ yrs. _____ mos. _____ d

(Signed) _____ M.

_____, 191__ (Address) _____

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

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

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ d

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

The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the