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 Barton

Township Nashville
or
Village ~~Nashville Mo~~
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 46

Primary Registration District No. 5069

File No. 36750

Registered No. _____

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

FULL NAME James Denis Monroe

PERSONAL AND STATISTICAL PARTICULARS

SEX M | COLOR OR RACE W | SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

DATE OF BIRTH July (Month) 30 (Day), 1876 (Year)

AGE 39 yrs. 10 mos. 16 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. Ohio

PARENTS
NAME OF FATHER John Monroe
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio
MAIDEN NAME OF MOTHER Miss Lizzie Long
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Effie Monroe

(ADDRESS) Nashville Mo

Filed Nov 10, 1916 Claude J Crouch REGISTRAR
11/10-1916

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June (Month) 17 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Jun 1st, 1916, to June 17th, 1916, that I last saw her alive on June 12, 1916, and that death occurred, on the date stated above, at 6:30 pm.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

23A (Duration) ___ yrs. 28 mos. ___ ds.

Contributory (SECONDARY) _____ (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. K. Schoofer M. D.
11/10 1916 (Address) Jasper 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 Nashville Mo | DATE OF BURIAL June 18, 1916

UNDERTAKER Bowman | ADDRESS Pittsburg Ks

Revised United States Standard Certificate of Death

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

PLACE OF DEATH

County .....

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

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

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

[If death occur hospital or ins give its NAME of street and num

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH ..... (Month) ..... (Day) ....., 1 (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)

I HEREBY CERTIFY, that I attended deceased ....., 191....., to ....., 1
that I last saw h..... alive on ....., 1
and that death occurred, on the date stated above, at .....
The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

Contributory ..... (SECONDARY)
..... (Duration) ..... yrs. ..... mos.

(Signed) .....

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

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

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

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

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

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL 19
UNDERTAKER	ADDRESS