MARGIN RESERVED FOR BINDING

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: Carroll

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

Registration District No. 133 File No. 22 37015

Primary Registration District No. 5784 Registered No.

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

FULL NAME Lelia Mattox

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

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

DATE OF BIRTH: April (Month) 9 (Day), 1869 (Year)

AGE: 47 yrs. 6 mos. 24 ds. If LESS than 1 day, hrs. or min.?

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

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

PARENTS

NAME OF FATHER: Columbus C. Mattox

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

MAIDEN NAME OF MOTHER: Martha Brotherton

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. M. Mattox

(ADDRESS) Bogard R.R.

Filed Nov. 4, 1916 Ethel Wallace REGISTRAR

MEDICAL CERTIFICATE OF DEATH 2

DATE OF DEATH: Nov. (Month) 3 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Oct. 22, 1916, to Oct 22, 1916, that I last saw her alive on or Oct. 22, 1916 and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Paralysis (General)
From Softening of Brain

66 (Duration) 1 yrs. 7 mos. 12 ds.

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

(Signed) J. M. Wooden M. D.

Nov. 4, 1916 (Address) Bogard 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: Pleasant Hill Cemetery

DATE OF BURIAL: Nov 4, 1916

UNDERTAKER: J. W. Winninger

ADDRESS: Bogard

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

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.

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MARGIN RESERVED FOR BINDING