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

38286

PLACE OF DEATH

County Morgan

Township Morrow or Village ~~Country~~ or City _____ (NO. _____ St.; _____ Ward)

Registration District No. 598 File No. _____

Primary Registration District No. 5792 B Registered No. 35

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

FULL NAME Phebe Luckenbill

PERSONAL AND STATISTICAL PARTICULARS

SEX Female | COLOR OR RACE White | SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widow

DATE OF BIRTH Nov (Month) 27 (Day), 1830 (Year)

AGE 85 yrs. 9 mos. 10 ds. | If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Farmers Widow

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) Chacocta Co Ohio

PARENTS

NAME OF FATHER John Dayton

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

MAIDEN NAME OF MOTHER Cannot Learn

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jim Luckenbill

(ADDRESS) Versailles Mo

Filed Nov 9, 1916 A. J. Gunn REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sep (Month) 7 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Sep 1, 1916, to Sep 7, 1916, that I last saw her alive on Sep 6, 1916, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhea with age

121 B

162

(Duration) 105 yrs. ___ mos. 10 ds.

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

(Signed) H E Blackstein M. D.

Nov 10, 1916 (Address) Excelsior 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 Hopewell | DATE OF BURIAL Sep 9, 1916

UNDERTAKER A Kidwell | ADDRESS Versailles Mo

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