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: Boone

Township: ~~Mo~~

or Village: ~~McBaine~~

or City: Huntsdale (NO. ____ St.: ____ Ward)

Registration District No. 77

Primary Registration District No. 4045

File No. 5-39994

Registered No. 5

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

FULL NAME: Mary Alice Grindstaff

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

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

DATE OF BIRTH: 5 (Month) 14 (Day), 1878 (Year)

AGE: 38 yrs. 2 mos. 27 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country): Boone co mo

PARENTS

NAME OF FATHER: Sidney Grindstaff

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

MAIDEN NAME OF MOTHER: Sophia Austeel

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Ada Powers

Yes F B W (ADDRESS): McBaine Mo

Filed ~~Aug 13~~ Dec-10, 1916. F B Williamson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: 8 (Month) 11 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 1, 1916, to Aug 11, 1916, that I last saw her alive on Aug 11, 1916, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

01

(Duration) — yrs. — mos. 11 ds.

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

(Signed) F B Williamson M. D.

8/13, 1916 (Address) McBaine 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: Mission Cem

DATE OF BURIAL: 8/13, 1916

UNDERTAKER: Parker Tur Co

ADDRESS: Columbia Mo

MISSOURI STATE BOARD OF HEALTI
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 occurred in 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 fr _____, 191____, to _____, 191_

that I last saw h _____ alive on _____, 191_

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) _____ M.

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, st (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. ____

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

Medical Association.)

the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report