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

41828

PLACE OF DEATH

County: Marion

Township or Village or City: Ft Liberty / Palmyra

Registration District No. 548 — File No.

Primary Registration District No. 5740 — Registered No. 60

(NO. ____ St.: ____ Ward)

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

FULL NAME Mrs. Julia A Mann

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female — COLOR OR RACE: White — SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

DATE OF BIRTH: May 27th 1825 (Month) (Day) (Year)

AGE: 91 yrs. 6 mos. 18 ds. — If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): Just boarding

BIRTHPLACE (City or town, State or foreign country): Kentucky

PARENTS

NAME OF FATHER: Henry B Dunn

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

MAIDEN NAME OF MOTHER: Nancy Wilson

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. C. Dunn

(ADDRESS) Philadelphia Mo

Filed Dec. 16, 1916 — Stanford, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Dec 15th (Month) (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 12th, 1916, to Dec 14th, 1916, that I last saw her alive on Dec 14th, 1916, and that death occurred, on the date stated above, at 5 A.m.

The CAUSE OF DEATH* was as follows:

Senility

66 82A 162

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

Contributory (SECONDARY): Paralytic Stroke

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

(Signed) J. C. Luckenbaugh M. D.

Dec 16th 1916 (Address) Palmyra 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: Benbow Mo — DATE OF BURIAL: Dec 17 1916

UNDERTAKER: N A McAllen — ADDRESS: Philmo

PLACE OF DEATH

MISSOURI STATE BOARD OF H
BUREAU OF VITAL STATISTIC
CERTIFICATE OF DEATH

Revised United States Standard

County.....

Township ..... Registration District No. ..... File No. .....
or
Village..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ..... , ... St.; ..... Ward)

[If death
hospital
give its
of street a

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

..... (Month) (Day

I HEREBY CERTIFY, that I attended dece

..... , 191..... , to .....

that I last saw h..... alive on .....

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 C
(1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN
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 BUR
UNDERTAKER	ADDRESS