612

# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

**PLACE OF DEATH**

County: Newton

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

Registration District No.: 612 / 612

Primary Registration District No.: 5814 / 5814

File No.: 41960

Registered No.: 132

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

**FULL NAME** Edward Devine

**PERSONAL AND STATISTICAL PARTICULARS**

| SEX | COLOR OR RACE | SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) |
|---|---|---|
| Male | White | Single |

DATE OF BIRTH: Sept. (Month) 16 (Day), 1878 (Year)

AGE: 38 yrs. 1 mos. 22 ds. If LESS than 1 day, — hrs. or — min.?

OCCUPATION (a) Trade, profession, or particular kind of work: Farm Hand

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

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

PARENTS

NAME OF FATHER: John Devine

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

MAIDEN NAME OF MOTHER: Catherine Kilduff

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Elfa Devine

(ADDRESS): Pentwood Mo

Filed Nov 6, 1916. J. T. Lazenby Registrar

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH: Nov. (Month) 6 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from March, 1916, to Nov. 6, 1916, that I last saw him alive on Sept. 20, 1916, and that death occurred, on the date stated above, at 5:15 A. m.

The CAUSE OF DEATH* was as follows:

23A

Tuberculosis of Lungs, 1 yr. 2 mos.

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) E. B. Wright M. D.

Nov. 6, 1916 (Address) Pierce City 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 | DATE OF BURIAL |
|---|---|
| Pierce City Mo | Nov 8, 1916 |
| **UNDERTAKER** | **ADDRESS** |
| John Simpson | Pierce City Mo |

V. S. No. 2.

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.

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.

V. S. No. 2.

# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

**PLACE OF DEATH**

County Lawrence

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

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

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

[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<br>MARRIED<br>WIDOWED<br>OR DIVORCED<br>(*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), 191..... (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<br>....., 191... |
|---|---|
| UNDERTAKER | ADDRESS |