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

974

PLACE OF DEATH

County Greene

Township 1st Campbell

or

Village

or

City Springfield (NO. R F D #2 St.; Ward)

Registration District No. 318

File No.

Primary Registration District No. 5440

Registered No. 70

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

FULL NAME Mary A Dunwright

PERSONAL AND STATISTICAL PARTICULARS

SEX Fem

COLOR OR RACE W

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widow

DATE OF BIRTH Oct 17, 1836 (Month) (Day) (Year)

AGE 80 80 yrs. mos. ds.

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

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

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

BIRTHPLACE (City or town, State or foreign country) MO

PARENTS

NAME OF FATHER John Wilkerson

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

MAIDEN NAME OF MOTHER Dent Knox

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. E. Webb

(ADDRESS) Springfield Mo

JAN 25 1917

Filed , 191 Edw H Jones REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jany 24, 1917 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jany 15, 1917, to Jany 24, 1917, that I last saw her alive on Jany 19, 1917, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

La Grippe and Senility 10

11B

11V (Duration) yrs. mos. 20 ds.

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

(Signed) D. A. Sherman M. D.

Jany 25 1917 (Address) Springfield 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 Rhodes Lone Cem

DATE OF BURIAL Jan 26, 1917

UNDERTAKER Jackson Mo

ADDRESS E A [illegible] South

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

..... (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

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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