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 import-

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

PLACE OF DEATH

County New Madrid

Township ~~[illegible]~~

or Village

or City Gideon (NO. ..... St.: ..... Ward)

Registration District No. 55 File No. 2279-B

Primary Registration District No. 554033 Registered No. 80

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

FULL NAME Jane Ramsey

PERSONAL AND STATISTICAL PARTICULARS

SEX Female

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widowed

DATE OF BIRTH May 6 (Month) (Day) 1856 (Year)

AGE 60 yrs. 8 mos. 8 ds.

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

OCCUPATION
) Trade, profession, or articular kind of work House Keeping

) General nature of industry, siness, or establishment in hich employed (or employer) Same

RTHPLACE City or town, ate or foreign country) Mulkey Town Ill

NAME OF FATHER Henry Fletcher

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

MAIDEN NAME OF MOTHER Jula Dawson

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

E ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

formant) Elsie Johnson

(ADDRESS) Dunquoin Ill

ed 2/1, 1917. M. V. Munn REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 14 (Month) (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 27, 1916, to Jan 11, 1917, that I last saw her alive on Jan 11, 1917, and that death occurred, on the date stated above, at 6 28 P m.

The CAUSE OF DEATH* was as follows:

Abcess of Right Lung

114B

(Duration) 18 yrs. ..... mos. ..... ds.

Contributory (SECONDARY) .....

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

(Signed) Thos W Cattrell M. D.

Jan 14, 1917 (Address) Gideon

*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 Blanefield

DATE OF BURIAL 1-15, 1917

UNDERTAKER Os. Conyers

ADDRESS Gideon Mo

V. S. No. 2.

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MISSOURI STATE BOARD OF HEALT

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 i hospital or instituti give its NAME inst 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) (Ye

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, s (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