LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT R

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSI
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIO

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PR

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

6841

1 PLACE OF DEATH

County: Monroe

Township: Union

or

Village:

or

City: (NO. , St., Ward)

Registration District No. 580

Primary Registration District No. 5777

File No.

Registered No. 37

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

2 FULL NAME: Electa Jane Williams

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): W

6 DATE OF BIRTH: July (Month) 18 (Day), 1839 (Year)

7 AGE: 77 yrs. 6 mos. 25 ds.

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

8 OCCUPATION
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (City or town, State or foreign country): N. Y.

PARENTS

10 NAME OF FATHER: Lovin Blossom

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): N Y

12 MAIDEN NAME OF MOTHER: Lara Brownell

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): L. A. Williams

(Address): Mobry Mo

15 Filed 2/14, 1917. E. C. Brooks, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb (Month) 13 (Day), 1917 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 22, 1917, to Feb 13, 1917, that I last saw her alive on Feb 13, 1917, and that death occurred, on the date stated above, at 3.35 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of lower lip — 45A 39

(Duration) 1 yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) P C Davis M. D.

Feb. 13, 1917 (Address) Madison Mo - R-5

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 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

19 PLACE OF BURIAL OR REMOVAL: Middle Grove Cemetery

DATE OF BURIAL: 2/14, 1917

20 UNDERTAKER: Fred A. Thompson

ADDRESS: Madison, Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association.]

MISSOURI STATE BOARD
BUREAU OF VITAL STAT
CERTIFICATE OF DEA

1 PLACE OF DEATH

County .....

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

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ....., 1..... (Day) (Year)

7 AGE

.....yrs. .....mos. .....ds.

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

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

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

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DE

16 DATE OF DEATH

..... (Month)

17 I HEREBY CERTIFY, that I atte

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

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

and that death occurred, on the date stated ab

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) .....yrs.

CONTRIBUTORY .....
(Secondary)

..... (Duration) .....yrs.

(Signed) .....

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from (1) Means of Injury; and (2) whether Accidental, Sui

18 LENGTH OF RESIDENCE (For Hospitals, Instit or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL

DATE

20 UNDERTAKER

ADDRE

"Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough;*