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.

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

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

PLACE OF DEATH

County Ralls

Township or Village or City Perry Mo (NO. ______ St.; ______ Ward)

Registration District No. 727 File No. 7217

Primary Registration District No. 4433 Registered No. 9

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

FULL NAME Ann Jane Yancey

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

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

DATE OF BIRTH: Dec (Month) 3 (Day), 1849 (Year)

AGE: 68 yrs. 1 mos. 13 ds. If LESS than 1 day, ___hrs. or ___min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): —

BIRTHPLACE (City or town, State or foreign country): Ralls Co Mo

PARENTS

NAME OF FATHER: Patric Nelson

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

MAIDEN NAME OF MOTHER: Pallye Bonnet

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) N. H. Adkisson

(ADDRESS) Hannibal Mo

Filed Mch 10th 1917 F Waller REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from Feb 13th, 1916, to Feb 16th, 1917, that I last saw her alive on Feb 15th, 1917, and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Intestitial Nephritis

131 / 170

(Duration) not known yrs. ___ mos. ___ ds.

Contributory (SECONDARY) ______ (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) F Waller M. D.

Feb 17th 1917 (Address) Perry 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: Walla Walla Wash

DATE OF BURIAL: ~~Feby~~ 17. 1917

UNDERTAKER: Geo C Rowell

ADDRESS: Perry Mo

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

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), 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 ____________, 191____

UNDERTAKER | ADDRESS