**PLACE OF DEATH**

County Audrain

Township Rrore

or

Village

or

City (NO. , St.; Ward)

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

Registration District No. 24 File No. 9054

Primary Registration District No. ~~4018~~ 5033 Registered No.

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

FULL NAME Arbela. C Covey,

**PERSONAL AND STATISTICAL PARTICULARS**

SEX Fe

COLOR OR RACE W.

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) widow

DATE OF BIRTH Sept 16, 1844 (Month) (Day) (Year)

AGE 73 yrs. mos. ds.

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

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

(b) General nature of industry, business, or establishment in which employed (or employer) 108 132

BIRTHPLACE (City or town, State or foreign country) South Valley N Y.

PARENTS

NAME OF FATHER Albert Hanson,

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

MAIDEN NAME OF MOTHER Cathern Atkins

BIRTHPLACE OF MOTHER (City or town, State or foreign country) N Y.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Hanson

(ADDRESS) Goddonia

Filed Mch, 1917. T M Monroe REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH Mch 26, 1917 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mch 24, 1917, to Mch 26, 1917, that I last saw her alive on Mch 26, 1917, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia & Bright's Disease of Kidney

(Duration) 92 yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) T M Monroe M. D.

Mch 26 1917 (Address) Goddonia

*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~~ Goddonia

DATE OF BURIAL Mch 29, 1917

UNDERTAKER McCoy

ADDRESS Goddonia

PLACE OF DEATH

# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE 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 _____ (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 |