

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.

PLACE OF DEATH

County MontgomeryTownship Danville

or

Village New Florence Mo

or

City _____ (NO. _____ St. _____ Ward _____)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHRegistration District No. 393File No. 11418Primary Registration District No. 3786 B

Registered No. _____

FULL NAME Rebeckey Austin

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

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) <u>widowed</u>
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DATE OF BIRTH Feb 23, 1836
(Month) (Day) (Year)AGE 81 yrs. 1 mos. 12 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) North CarolinaNAME OF FATHER Sherwood KennedyBIRTHPLACE OF FATHER
(City or town, State or foreign country) North CarolinaMAIDEN NAME OF MOTHER Alice ConnardBIRTHPLACE OF MOTHER
(City or town, State or foreign country) Not Known

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Sam Anderson(ADDRESS) New FlorenceFiled Mar 3 1917 E E Evans
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 2 March 4, 1917
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Feb 28th, 1917, to March 4th, 1917, that I last saw her alive on March 4th, 1917, and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart74 (Duration) two yrs. ____ mos. ____ ds.Contributory to old-age
(SECONDARY) (Duration) ____ yrs. ____ mos. 5 ds.(Signed) F. P. Wyatt M. D.Mar 5th, 1917 (Address) New Florence

*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 Mt Pleasant DATE OF BURIAL Mar - 6, 1917UNDERTAKER M. L. Stuart ADDRESS New Florence MO.

PLACE OF DEATH

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

County _____
 Township _____
 or _____
 Village _____
 or _____
 City _____

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

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
 (If write the word)

DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year) _____
 IF LESS than
 1 day, _____ hrs.
 or _____ min.?

AGE _____ yrs. _____ mos. _____ ds.

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)

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____, 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:

Contributory

(SECONDARY)

(Signed) _____

(Address) _____

M. D.

*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 _____

UNDERTAKER _____

ADDRESS _____

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.