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.

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

**PLACE OF DEATH**

County: Chariton

Township: Cockrell

or Village:

or City: (NO. , St.; Ward)

Registration District No. 960 File No. 18080

Primary Registration District No. 5247 Registered No. 10.

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

**FULL NAME** Edward Preston

**PERSONAL AND STATISTICAL PARTICULARS**

SEX: Male

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): widowed

DATE OF BIRTH: January 5, 1830 (Month) (Day) (Year)

AGE: 87 yrs. 5 mos. 27 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE (City or town, State or foreign country): Durham, England

PARENTS

NAME OF FATHER: Thomas Preston

BIRTHPLACE OF FATHER (City or town, State or foreign country): no records

MAIDEN NAME OF MOTHER: No Record

BIRTHPLACE OF MOTHER (City or town, State or foreign country): No Record

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Duncan P. Preston

(ADDRESS) Hamden R. F. D #1

Filed May 28, 1917 Chas. A. Clarkson REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH: May (Month) 27 (Day), 1917 (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 11 P. m.

The CAUSE OF DEATH* was as follows:

Senile Debility & Inanition

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

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

(Signed) J. D. McAdam M. D.

May 28 1917 (Address) Prairie Hill

*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: Harr View Cem

DATE OF BURIAL: May 28 1917

UNDERTAKER: P. P. Preston

ADDRESS: Mussel Fork Mo.

## PLACE OF DEATH

County _____

Township _____
or
Village _____
or
City _____ (NO. _____, _____ St.; _____ Ward)

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

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

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

**FULL NAME** _____

**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.

### 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) (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