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 Knox

Township Center

or

Village

or

City Edina Mo (NO. ____ St. ____ Ward)

Registration District No. 441 File No. 19097

Primary Registration District No. 4259 Registered No. 26

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

FULL NAME Mrs Flora B Sheehy

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: white

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

DATE OF BIRTH: Sep (Month) 29 (Day), 1872 (Year)

AGE: 45 yrs. 7 mos. 8 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): Newton Iowa

PARENTS
NAME OF FATHER: W C Wood
BIRTHPLACE OF FATHER (City or town, State or foreign country): Indianna
MAIDEN NAME OF MOTHER: Eliza Vaughn
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F E Sheehy

(ADDRESS) Edina Mo

Filed June 10 1917. H. J. Jurgens REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: May (Month) 6 (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from May 6, 1917, to May 6, 1917, that I last saw her ~~alive~~ dead on May 6, 1917, and that death occurred, on the date stated above, at 11.50 P m.

The CAUSE OF DEATH* was as follows:

131
Gastritis 170
118 C

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

Contributory (SECONDARY) Arephritis Chronic

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

(Signed) J G Keaney Jr M. D.

May 6 1917 (Address) Edina 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: New Catholic Cem

DATE OF BURIAL: May 8 1917

UNDERTAKER: Wudd & Jarvis

ADDRESS: Edina Mo

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 .....

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