

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 Greensburg
or Baring
Village Baring
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 439 File No. 22505
Primary Registration District No. 5596 Registered No. 62

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

FULL NAME Mary Brennan

PERSONAL AND STATISTICAL PARTICULARS

SEX female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)

DATE OF BIRTH May 10, 1893
(Month) (Day) (Year)

AGE 24 yrs. 13 mos. 13 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work None 25
(b) General nature of industry, business, or establishment in which employed (or employer) none 810

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

PARENTS
NAME OF FATHER James Brennan
BIRTHPLACE OF FATHER Ireland
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Mary Kronan
BIRTHPLACE OF MOTHER Mo
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Brennan
(Address) Baring Mo

Filed June 24, 1917 Georgewacker
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 23rd, 1917
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 8th, 1917, to May 8th, 1917, that I last saw her alive on May 8th, 1917, and that death occurred, on the date stated above, at 2 P.m.
The CAUSE OF DEATH* was as follows: Epilepsy
from birth Wife
An idiot

Contributory (SECONDARY) W.F. Garner M. D.
(Signed) June 23, 1917 (Address) Baring 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 Baring Cem DATE OF BURIAL June 25, 1917

UNDERTAKER Mudd & Jarvis ADDRESS Edina

(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**

County HTASCO TO STAGHITRES Township OK CITY Registration District No. 12 File No. 121
 or Village OK CITY Primary Registration District No. 12 Registered No. 121
 City, town or place OK CITY (If death occurred in a hospital or institution, give its NAME instead of street and number)
 Ward OK

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED	DATE OF BIRTH	AGE
			(Month) (Day) (Year)	(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from _____, 191____, at _____, 191____, that I last saw him alive on _____, 191____, and that death occurred on the date stated above, at _____, 191____.				
The CAUSE OF DEATH* was as follows: _____ to _____ to _____ to _____				

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 _____

CAUSE OF DEATH

DATE OF DEATH _____
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, at _____, 191____, that I last saw him alive on _____, 191____, and that death occurred on the date stated above, at _____, 191____.

The CAUSE OF DEATH* was as follows: _____
 to _____
 to _____
 to _____

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

(Signed) _____
 (Duration) _____ yrs. _____ mos. _____ ds.

***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 _____ yrs. _____ mos. _____ ds. State _____
 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) _____

DATE OF BURIAL _____, 191____

ADDRESS _____