

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 Pettis
 or
 Townshp Smithton
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

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

Registration District No. 669 File No. 22938
 Primary Registration District No. 5892 Registered No. 13

FULL NAME

Aetna Jane Homan

[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 <u>married</u> WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>Sept.</u> <u>17</u> , 19 <u>32</u> (Month) (Day) (Year)		
AGE <u>64</u> yrs. <u>9</u> mos. <u>2</u> ds.		If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housework</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		
BIRTHPLACE (City or town, State or foreign country) <u>Indiana</u>		
PARENTS	NAME OF FATHER <u>W. H. Taylor</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Indiana</u>	
	MAIDEN NAME OF MOTHER <u>0</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>4</u>	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clara Homan

(ADDRESS) Smithton Mo

Filed July 2, 1917, S. M. Parrish
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 19, 1917
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1917, to June 19, 1917,
 that I last saw her alive on June 19, 1917,
 and that death occurred, on the date stated above, at 11:00 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of
stomach
465
 (Duration) ___ yrs. ___ mos. ___ ds.

Contributory

(SECONDARY)

(Duration) ___ yrs. ___ mos. ___ ds.
 (Signed) Sam M. Parrish M. D.
June 20, 1917 (Address) Smithton 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

Smithton

DATE OF BURIAL

June 21, 1917

UNDERTAKER

Newmeyer

ADDRESS

Smithton

PLACE OF DEATH

County _____

Township _____
or _____Village _____
or _____

City _____

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

(NO _____)

St. _____

[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) _____

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

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

(Month) _____, 191_____ (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) _____, 191_____, M. D.

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

(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 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

191_____