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

Hemet

PLACE OF DEATH

County Jasper

Township Marion

or Village

or City Carthage (NO. ____ St.; ____ Ward)

Registration District No. 408 File No. 25510

Primary Registration District No. 3020 Registered No. 164

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

FULL NAME Matilda C. Lake

PERSONAL AND STATISTICAL PARTICULARS

SEX Female

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

DATE OF BIRTH June (Month) 11 (Day), 1847 (Year)

AGE 70 yrs. 1 mos. 18 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) Warren's Point Ireland

PARENTS

NAME OF FATHER Jos. Remons

BIRTHPLACE OF FATHER (City or town, State or foreign country) England

MAIDEN NAME OF MOTHER Sturgeon

BIRTHPLACE OF MOTHER (City or town, State or foreign country) England

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mollie Richardson

(ADDRESS) Carthage, Mo

Filed 7/31, 1917. C. B. Taylor

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July (Month) 29 (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from July 27, 1917, to July 29, 1917, that I last saw her alive on July 29, 1917, and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

Cerebral Hæmorrhage

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

Contributory (SECONDARY) Acute Indigestion

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

(Signed) David Wise M. D.

July 30, 1917 (Address) 330 Grant St

*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 Park Cemetery

DATE OF BURIAL July 31, 1917

UNDERTAKER Snell Undg Co

ADDRESS Carthage

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

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.

PLACE OF DEATH

County .....

Township ..... or Village ..... or City .....

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

(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 (*Write the word*)

DATE OF BIRTH

..... (Month) ..... (Day) ....., 1..... (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) .....

MAR 2 8 1958

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

..... (Month) ..... (Day), *191*..... (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