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: Shelby

Township: Black Fork
or
Village:
or
City: (NO. St.; Ward)

Registration District No. 831 File No. 27482

Primary Registration District No. ~~4604~~ 6097 Registered No. 19

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

FULL NAME Ins Kate Hall

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

DATE OF BIRTH: Not known (Month) (Day) (Year)

AGE: About 70 yrs. mos. 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): X

BIRTHPLACE (City or town, State or foreign country): Not known

PARENTS
NAME OF FATHER: Matt Mountain
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) J M Hall

(ADDRESS) Shelbyville Mo.

Filed July 8 1917 W. C. Carter REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: July 7 (Month) (Day) 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 1916, to July 1917, that I last saw her alive on July 5 1917, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Lesion

92H 7A

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) E E Salyer M. D.

July 8 1917 (Address) Shelbyville 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) Co Infirmary

At place of death 12 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: Infirmary Cemetery

DATE OF BURIAL: July 8 1917

UNDERTAKER: J M Humphrey & Sons

ADDRESS: Shelbyville, Mo.

PLACE OF DEATH

MISSOURI STATE BOARD OF H
BUREAU OF VITAL STATISTIC
CERTIFICATE OF DEATH

County.....

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

or

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

or

City .....(NO....., ...St.....Ward) [If death hospital give its N of street a

FULL NAME.....

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

.....
(Month) (Day

I HEREBY CERTIFY, that I attended dece

....., 191...., to.....

that I last saw h.....alive on.....

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

Contributory.....
(SECONDARY)

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

(Signed).....

....., 191.... (Address).....

*State the Disease Causing Death, or, in deaths from Violent C (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BUR
UNDERTAKER	ADDRESS

Revised United States Standard

"Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite);