MARGIN RESERVED FOR BINDING

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.

V. S. No. 2.

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

PLACE OF DEATH

County Bollinger

Township Liberty

or

Village

or

City (NO. , St.: Ward)

Registration District No. 940 File No. 30999-a

Primary Registration District No. 5104 Registered No. 13

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

FULL NAME Mary Landeway

PERSONAL AND STATISTICAL PARTICULARS

SEX Female

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

DATE OF BIRTH Nov. (Month) 10 (Day), 1877 (Year)

AGE 39 yrs. 8 mos. 29 ds.

If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Leopold Mo

PARENTS

NAME OF FATHER John Englen

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

MAIDEN NAME OF MOTHER Mary Vardeven

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Herman Landeway

(ADDRESS) Leopold Mo.

Filed Nov 14, 1917. C A Sander REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sep. (Month) 7 (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from Aug. 5, 1917, to Sep 7, 1917, that I last saw her alive on Sep 7, 1917, and that death occurred, on the date stated above, at 10 P.m.

The CAUSE OF DEATH* was as follows:

1 Typhoid fever. Complicated
3 with Malaria, Bowlenbowel
12 [illegible]

01

(Duration) yrs. 1 mos. 2 ds.

Contributory (SECONDARY) Typhoid fever.

(Duration) yrs. mos. ds.

(Signed) J. M. Finney M. D.

Sep 8, 1917 (Address) Whitewater 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 Leopold, Mo

DATE OF BURIAL Sept 8, 1917

UNDERTAKER A R Lutes

ADDRESS Lutesville Mo

PLACE OF DEATH

County _____

Township _____
or
Village _____
or
City _____ (NO. _____, _____ St.; _____ Ward)

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

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[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 _____ (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), 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