CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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

32554

1 PLACE OF DEATH

County Monroe

Township Marion or Village or City (NO. St.; Ward)

Registration District No. 599 File No.

Primary Registration District No. 5776 Registered No.

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

2 FULL NAME Jno W. Lenhart

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Mar (Month) 5 (Day) 1852 (Year)

7 AGE 65 yrs. 6 mos. 25 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country) Pa

PARENTS

10 NAME OF FATHER Jacobie Lenhart

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

12 MAIDEN NAME OF MOTHER Nancy Williams

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Tryphene Lenhart

(Address) Madison Mo

15 Filed 10/1 1917 F. A. Thompson Deputy W. Weubank Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. (Month) 30th (Day) 1917 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Feb. 1917 to Sept. 30th 1917, that I last saw him alive on Sept. 1917, and that death occurred, on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.C.

23A 28

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. E. Lewis M. D.

Oct. 3rd 1917 (Address) Madison

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

18 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

19 PLACE OF BURIAL OR REMOVAL Madison Cemetery

DATE OF BURIAL 10/1 1917

20 UNDERTAKER Fred A. Thompson

ADDRESS Madison Mo

Revised United States Standard Certificate of Death

"Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc. of

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death c
hospital or
give its NA
of street an

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH
..... (Month) ..... (Day), 1 ..... (Year)

7 AGE
..... yrs. ..... mos. ..... ds.
If LESS than 1 day, ... hrs. or ..... min.?

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

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (City or town, State or foreign country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15
Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
..... (Month) ..... (Day), 1

17 I HEREBY CERTIFY, that I attended deces
....., 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 Ca
(1) Means of Injury; and (2) whether Accidental, Suicidal or H

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tr
or 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 .....

19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL .....

20 UNDERTAKER | ADDRESS