

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 Monroe
Township Green
or
Village Camell Mo.
or
City _____ (NO. _____ Ward _____)

Registration District No. 1057 File No. 34122
Primary Registration District No. 6214 Registered No. 4

FULL NAME

Sarah Elizabeth Stiles

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

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White ☒ SINGLE ☐ MARRIED ☐ WIDOWED ☐ OR DIVORCED Married
(If ~~widowed~~ ~~divorced~~ ~~the widow~~)

DATE OF BIRTH Age 27- 846
1 (Month) (Day) (Year)

AGE 27 yrs. 9 mos. 25 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) Seam's wife

BIRTHPLACE

(City or town, State or foreign country) Camell Mo.

PARENTS
NAME OF FATHER Samuel Calvin
BIRTHPLACE OF FATHER Indiana
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Betty Adams
BIRTHPLACE OF MOTHER Indiana
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Herna Stiles

(ADDRESS) Camell Mo.

Filed Sept. 23, 1917 T. M. Cox

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept. 22, 1917
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sep 16, 1917, to Sep 22, 1917, that I last saw her alive on Sep 22, 1917, and that death occurred, on the date stated above, at 2 P.m. The CAUSE OF DEATH was as follows:

Lobar Pneumonia
108
(Duration) 9 yrs. 7 mos. 25 ds.

Contributory (SECONDARY)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) L. B. M. Jr. M. D.
Sep 22, 1917 (Address) Camell 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

Camell Mo.

DATE OF BURIAL

9-28, 1917

UNDERTAKER

Prof. LaFam

ADDRESS

Camell Mo.

PLACE OF DEATH

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

County _____

Township _____ or _____

Village _____ or _____

City _____ (NO. _____) St. _____ Ward _____

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

PERSONAL AND STATISTICAL PARTICULARS			
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	
DATE OF BIRTH		(Month) _____ (Day) _____ (Year) _____	
AGE		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 _____	

MEDICAL CERTIFICATE OF DEATH	
DATE OF DEATH	_____ (Month) _____ (Day) _____, 191 _____
I HEREBY CERTIFY, that I attended deceased from _____, 191 _____, to _____, 191 _____, that I last saw him alive on _____, 191 _____, and that death occurred, on the date stated above, at _____.	
The CAUSE OF DEATH* was as follows:	

_____ (Duration) _____ yrs. _____ mos. _____ ds.	
Contributory (SECONDARY) _____	
(Signed) _____ (Address) _____ M. D.	
*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