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 Barton

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

Registration District No. 40 File No. 37412

Primary Registration District No. 4024 Registered No. 42

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

FULL NAME Mary Angeline Gentry

PERSONAL AND STATISTICAL PARTICULARS

SEX: female

COLOR OR RACE: white

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): widow

DATE OF BIRTH: Oct (Month) 17 (Day), 1836 (Year)

AGE: 81 yrs. 1 mos. 8 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): 108 92A 130A

BIRTHPLACE (City or town, State or foreign country): Ralls Co - Mo.

PARENTS
NAME OF FATHER: Stephen Elliott
BIRTHPLACE OF FATHER (City or town, State or foreign country): unknown
MAIDEN NAME OF MOTHER: Lavina Redman
BIRTHPLACE OF MOTHER (City or town, State or foreign country): unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F K Gentry

(ADDRESS) Nevada Mo.

Filed Nov 26 1917 Hoyt Humphrey Dep REGISTRAR

MEDICAL CERTIFICATE OF DEATH 3

DATE OF DEATH: 11 (Month) 25 (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 26, 1917, to Nov 24, 1917, that I last saw her alive on November 24, 1917, and that death occurred, on the date stated above, at 2:20 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Complicate with Valvular Heart Lesion an Uremic Convulsions

29 Days (Duration) — yrs. — mos. — ds.

Contributory (SECONDARY) _____ (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. F. Cromley M. D.

Nov 26 1917 (Address) Lamar 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: Sheldon Mo

DATE OF BURIAL: Nov 27 1917

UNDERTAKER: Hoyt Humphrey

ADDRESS: Lamar Mo

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

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 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

..... , 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

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