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

38903

1 PLACE OF DEATH

County Monroe

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

Registration District No. 579 File No.

Primary Registration District No. 5716 Registered No.

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

2 FULL NAME David H. Dry

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX Male

4 COLOR OR RACE White

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

6 DATE OF BIRTH May (Month) 6 (Day) 1848 (Year)

7 AGE 69 yrs. 6 mos. 16 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) Monroe C Mo

PARENTS

10 NAME OF FATHER Elye Dry

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

12 MAIDEN NAME OF MOTHER Rebecca Hickman

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. L. Cornelius

(Address) Madison, Mo.

15 Filed Nov 23 1917 W W Eubank Fred A. Thompson Deputy Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH Nov. (Month) 22nd (Day) 1917 (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 1914, to Nov. 22nd 1917, that I last saw him alive on Nov. 21st 1917, and that death occurred, on the date stated above, at 8 A.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

92A

79

(Duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

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

(Signed) M. E. Lensley, M. D.

Nov. 23rd 1917 (Address) Madison Mo

*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 Union Cemetery

DATE OF BURIAL Nov 24 1917

20 UNDERTAKER Fred A. Thompson

ADDRESS Madison

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

1917-11-22
1918-3-6

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 occu hospital or in give its NAME of street and n

2 FULL NAME .....

**MISSOURI STATE BOARD OF HEA**
**BUREAU OF VITAL STATISTICS**
**CERTIFICATE OF DEATH**

**Revised United States Standard Certificate of Death**

## PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH

....., 1.....
(Month) (Day) (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

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

17 I HEREBY CERTIFY, that I attended decease

....., 191....., to....., 19

that I last saw h.....alive on....., 19

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 Caus (1) Means of Injury; and (2) whether Accidental, Suicidal or Hom

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tran 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

....., 1

20 UNDERTAKER

ADDRESS

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