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

38904

1 PLACE OF DEATH

County: Monroe

Township: Union
or
Village:
or
City: (NO. St.; Ward)

Registration District No. 580

Primary Registration District No. 577

File No.

Registered No. 12

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

2 FULL NAME Margret E. Wooldridge

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): W

6 DATE OF BIRTH: June (Month) 22 (Day), 1841 (Year)

7 AGE: 76 yrs. 5 mos. 7 ds.

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

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

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

PARENTS

10 NAME OF FATHER: Tom Wilcox

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

12 MAIDEN NAME OF MOTHER: Patsy Brookshire

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Willie Elsberry
(Address) Madison Mo

15
Filed Dec 1, 1917 E C Brooks Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov. 30th (Month) (Day), 1917 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov. 30, 1917, to Nov 30, 1917, that I last saw her alive on Nov. 30, 1917, and that death occurred, on the date stated above, at 5:00 A.m.

The CAUSE OF DEATH* was as follows:
Chronic Mitral
Regirgitation
92.A

(Duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) P C Davis M. D.
Dec 1, 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: Hall Cemetery
DATE OF BURIAL: Dec 2, 1917

20 UNDERTAKER: Fred A. Thompson
ADDRESS: Madison Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

Revised United States Standard Certificate of Death

1 PLACE OF DEATH

County Monroe

Township Union
or
Village
or
City (NO. , St. Ward)

Registration District No. File No.

Primary Registration District No. Registered No

(If death hospital or give its NA of street an

2 FULL NAME Margrett L. Worledge

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) W—

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 C (1) Means of Injury; and (2) whether Accidental, Suicidal or H

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, T 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

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