

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 42219

PLACE OF DEATH
County Pennsacola
Township Little Prairie Registration District No. 057 File No.
or
Village Primary Registration District No. 5802 Registered No. 203
or
City (NO. St. Ward)

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

2 FULL NAME Nannie M. Abionathy

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH Sept 28 1853
(Month) (Day) (Year)

7 AGE 64 yrs 2 mos 12 ds. If LESS than 1 day..... hrs. or..... min.?

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

9 BIRTHPLACE
(City or town, State or foreign country) Don't know

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) J. T. Cunningham
(Address) Camtherville, Mo.

15 Filed 12-10 1917 B. D. Larson
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 10th 1917
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 8th 1917 to Dec 10th 1917
that I last saw her alive on Dec 9th 1917
and that death occurred, on the date stated above, at 1:30 p.m.
The CAUSE OF DEATH was as follows:
100% Cardiac Failure

CONTRIBUTORY Heart Pneumonia
(Secondary) (Duration) 7 yrs..... mos..... ds.
(Signed) M. B. Hindley M. D.
Dec 10th 1917 (Address) Camtherville, 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 10 yrs..... mos..... ds. In the 10 yrs..... mos..... ds.
Where was disease contracted if not at place of death?
Former or usual residence Tennessee

19 PLACE OF BURIAL OR REMOVAL Olle Branch Miss DATE OF BURIAL Dec 12 1917

20 UNDERTAKER J. Lewis ADDRESS Camtherville, Mo.

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.

THIS IS A PERMANENT RECORD

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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 (name or

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CERTIFICATE OF DEATH

1 PLACE OF DEATH
County
Township
Village
City
Registration District No. File No.
Primary Registration District No. Registered No.
City (NO) St. Ward
(If decedent hospital give its of street

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) 191..... (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)

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)

17 I HEREBY CERTIFY, that I attended decedent 191..... to that I last saw him alive on and that death occurred, on the date stated above, at The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary) (Duration) yrs. m. (Signed) 191..... (Address)
*State the Disease Causing Death, or, in deaths from Violent (1) Means of Injury; and (2) whether Accidental, Suicidal
18 LENGTH OF RESIDENCE (For Hospitals, Institutions or Recent Residents) In the State yrs. mos. ds. At place of death yrs. mos. ds. State yrs. 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