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

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

63

PLACE OF DEATH

County Andrain

Township ~~Prairie~~ or Village or City Laddonia Mo (NO. ____ St.; ____ Ward)

Registration District No. 24 File No. ____

Primary Registration District No. 4018 Registered No. ____

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

FULL NAME Albina S Hale

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White ~~SINGLE~~ ~~MARRIED~~ WIDOWED OR DIVORCED (Write the word) widowed

DATE OF BIRTH Aug (Month) 17 (Day), 1838 (Year)

AGE 79 yrs. 4 mos. 19 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ____

BIRTHPLACE (City or town, State or foreign country) Vermont

PARENTS

NAME OF FATHER Dont Know

BIRTHPLACE OF FATHER (City or town, State or foreign country) Dont Know

MAIDEN NAME OF MOTHER Dont Know

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Dont Know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A B Hale

(ADDRESS) Laddonia Mo

Filed Jan 5, 1918 W K McCall REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

DATE OF DEATH Jan. (Month) 5 (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 29, 1917, to Jan 3, 1918, that I last saw her alive on Jan 4, 1918, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

General Paralysis due to Apoplexia

82 A
82 D 64 (Duration) ____ yrs. 2 mos. 6 ds.

16 Contributory (SECONDARY) age

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W K McCall M. D.

81-3-1918 (Address) Laddonia

*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 42 yrs. ____ mos. ____ ds. In the State 42 yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? ____

Former or usual residence none

PLACE OF BURIAL OR REMOVAL Laddonia Mo DATE OF BURIAL Jan 6 1918

UNDERTAKER W H Wilson ADDRESS Laddonia 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 .....

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

WRITE PLAINLY WITH UNFADING INK

—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible]