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

208

PLACE OF DEATH

County: Buch

Township: Center

or Village:

or City: (NO. , St.; Ward)

Registration District No. 80 File No.

Primary Registration District No. 5119 Registered No. 5

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

FULL NAME Thomas Jefferson Mount

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
male	white	W.D.

DATE OF BIRTH: October (Month) 16 (Day), 1841 (Year)

AGE: 76 yrs. 2 mos. 29 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country): Tennessee

PARENTS
NAME OF FATHER: Jefferson Mount
BIRTHPLACE OF FATHER (City or town, State or foreign country): Tennessee
MAIDEN NAME OF MOTHER: not known
BIRTHPLACE OF MOTHER (City or town, State or foreign country): not known

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Rosa Powell

(ADDRESS) Agency Mo.

Filed 1/14/18, 191__ R F Dowell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: January (Month) 12th (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from January 9th, 1918, to January 12, 1918, that I last saw him alive on January 12, 1918, and that death occurred, on the date stated above, at ___ m.

The CAUSE OF DEATH* was as follows:

108
12 A Lobar Pneumonia

(Duration) 0 yrs. 0 mos. 3 ds.

Contributory (SECONDARY) mitral stenosis

(Duration) 15 yrs. 0 mos. 0 ds.

(Signed) Dr. S. E. Meluney M. D.

Jan. 14, 1917 (Address) Agency 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: Register Cemetery

DATE OF BURIAL: Jan. 14, 1918

UNDERTAKER: H. A. Sullins

ADDRESS: Gower Mo.

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

PLACE OF DEATH

County _____

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

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[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 _____ (Month) _____ (Day), *1*____ (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 _____ (Month) _____ (Day), *191*____ (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, WITHIN LINE—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.