LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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

1 PLACE OF DEATH

County Monroe

Township Union — Registration District No. 580 — File No. 2149

or

Village — Primary Registration District No. 5777 — Registered No. 1

or

City (NO. St.; Ward)

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

2 FULL NAME Luvena F. Embree

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: Jan (Month) 20 (Day) 1868 (Year)

7 AGE: 49 yrs. 11 mos. 20 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): Randolph Co Mo

PARENTS

10 NAME OF FATHER: Thomas J Nichols

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

12 MAIDEN NAME OF MOTHER: Rebecca J Sipp

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J M Embree
(Address) Madison Mo R.R.

15 Filed 1/10 1918 E C Brooks Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 1 (Month) 10 (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 1, 1918, to Jan 10, 1918, that I last saw her alive on Jan 8, 1918, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:
Mitral Insufficiency following Asthma
112
920 79 (Duration) 2 yrs. 2 mos. 6 ds.

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

(Signed) [illegible] M. D.
Jan 10, 1918 (Address) Moberly 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: Madison Mo — DATE OF BURIAL: 1/11 1918

20 UNDERTAKER: Fred A. Thompson — ADDRESS: Madison Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

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 o
hospital or
give its NA
of street an

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) ..... (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 deceas

....., 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 Ca
(1) Means of Injury; and (2) whether Accidental, Suicidal or Ho

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tra
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

vised United States Standard

"Typhoid pneumonia"); *Lobar pneumonia; Broncho-*
pneumonia ("Pneumo