V. S. No. 2.

MARGIN RESERVED FOR BINDING

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.

5648-A

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

PLACE OF DEATH

County Iowa

Township ~~Holland~~ or Village Ewing or City ____ (NO. ____, ____ St.; ____ Ward)

Registration District No. 478 File No. 5648-A

Primary Registration District No. 4287 Registered No. 313

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

FULL NAME Ambrose D Clow

PERSONAL AND STATISTICAL PARTICULARS

SEX: male

COLOR OR RACE: white

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): widow

DATE OF BIRTH: September (Month) 24 (Day), 1829 (Year)

AGE: 88 yrs. 4 mos. 20 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

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

PARENTS

NAME OF FATHER: Amt Knox

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

MAIDEN NAME OF MOTHER: Amt Knox

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Isaac J. Clow

(ADDRESS) Ewing, Mo.

Filed ____, 191__. ____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: February (Month) 20 (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 18, 1918, to Feb 18, 1918, that I last saw him alive on Feb 18, 1918, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

91 (Duration) ____ yrs. 81 mos. ____ ds.

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

8 (Signed) C N Francis M. D.

Feb 21, 1918 (Address) Ewing 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: Brisco

DATE OF BURIAL: Feb 22, 1918

UNDERTAKER: F E Kinrick

ADDRESS: Ewing

MARGIN RESERVED FOR BINDING

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 HEALT

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 hospital or institutio give its NAME inste 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 fro

....., 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