

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.

PLACE OF DEATH

County Knox
Township Alt River
or
Village
or
City

Registration District No. 446

Primary Registration District No. 5066

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

File No. 13712 a

Registered No.

St. Ward

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

FULL NAME Permelia A Beck

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH April 6, 1916
(Month) (Day) (Year)

AGE 57 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

OCCUPATION (a) Trade, profession, or particular kind of work None Invalid
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Knox Co Mo

PARENTS NAME OF FATHER Jas C Beck
BIRTHPLACE OF FATHER (City or town, State or foreign country) Indiana
MAIDEN NAME OF MOTHER Larvena Alread
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jno. W. Hudson

(ADDRESS) Norvity Mo

Filed April 6, 1916 M E Hill

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 6, 1916
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from April 3d, 1916, to April 6, 1916, that I last saw her alive on April 6, 1916, and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Progressive Paralysis

82D 66
(Duration) 3 yrs. 4 mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) W W Owen M. D.

April 6, 1916 (Address) Norvity 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

Mt Carmel

DATE OF BURIAL

April 7, 1916

UNDERTAKER

Jno W Hudson

ADDRESS

Norvity Mo

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 HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____
Township _____
or Village _____
or _____
City _____
Registration District No. _____
Primary Registration District No. _____
File No. _____
Registered 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 (If fill the word)
DATE OF BIRTH _____ (Month) _____, 191____ (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)

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) _____, 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.

_____ (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. 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

UNDERTAKER

ADDRESS

191____