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

File No. 22149

Registration District No. 819

Primary Registration District No. 6065

Registered No. 7

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

PLACE OF DEATH

County: Scott

Township: Morley

or Village:

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

FULL NAME Mary Elizabeth West

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH: June (Month) 5 (Day) 1849 (Year)

AGE: 69 yrs. 6 mos. 16 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): Kentucky

PARENTS
NAME OF FATHER: William Monroe
BIRTHPLACE OF FATHER (City or town, State or foreign country): Kentucky
MAIDEN NAME OF MOTHER: Melinda Wilkz
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Kentucky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L R Graves

(ADDRESS) Morley Mo

Filed June 1918. Mrs. J. M. Pirtle REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: June (Month) 19 (Day) 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from May 21st 1918, to June 19 1918, that I last saw her alive on June 18 1918, and that death occurred, on the date stated above, at 805 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy
52R
77

64

(Duration) ....yrs. 1 mos. ....ds.

Contributory (SECONDARY): Cerebral Sclerosis

(Duration) 1 yrs. ....mos. ....ds.

(Signed) E. D. H. M. D.

June 19 1918 (Address) Morley 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	DATE OF BURIAL
Morley Cem	June 20 1918
UNDERTAKER	**ADDRESS**
C. D. M. Gupton	Morley 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 ..... (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