

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHCounty StoneTownship Lincoln

or

Village L

or

City LRegistration District No. 1044File No. 425371Primary Registration District No. 6257Registered No. 4

City (NO. St. Ward)

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

FULL NAME Mary E. Bland

PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH

AGE

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

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Andy Moore(ADDRESS) ElsevFiled July 18, 1918Phoe H. Hault
REGISTERAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

I HEREBY CERTIFY, that I attended deceased from

July 11, 1918, to July 17, 1918,that I last saw her alive on June 10, 1918,and that death occurred, on the date stated above, at 131 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis131(Duration) 10 yrs. 10 mos. 10 ds.Contributory L(Duration) 10 yrs. 10 mos. 10 ds.(Signed) N. L. Trarr M. D.(Address) Crane, 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 10 yrs. 10 mos. 10 ds. In the State 10 yrs. 10 mos. 10 ds.

Where was disease contracted If not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

Grail Spur CemeteryDATE OF BURIAL July 18, 1918

UNDERTAKER

W. E. Hill

ADDRESS

Crane Mo.

PLACE OF DEATH

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

County _____

Township _____ or Village _____ or City _____

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

(NO. _____ St. _____ Ward _____)

(If death occur hospital or in give its NAME 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) _____ (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 _____

DATE OF DEATH _____ (Month) _____ (Day) _____	MEDICAL CERTIFICATE OF DEATH
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I HEREBY CERTIFY, that I attended deceased _____, 191____, to _____, 1____, that I last saw him alive on _____, 1____, 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) _____ (Address) _____, 191____

*State the Disease Causing Death, or, in deaths from Violent Cause (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____
Where was disease contracted if not at place of death? _____
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
UNDERTAKER	ADDRESS