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.

35332-a

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

PLACE OF DEATH

County: Ralls

Township or Village: Clay

Registration District No.: 728

File No.: 35332-a 11

Primary Registration District No.: 5961

Registered No.: 79

City: ____ (NO. ____ St.: ____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Mary Johnson

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

DATE OF BIRTH: Apr 29, 1839 (Month) (Day) (Year)

AGE: 79 yrs. 5 mos. 29 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): 92A 125E

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

PARENTS
NAME OF FATHER: Wm Harrelson
BIRTHPLACE OF FATHER (City or town, State or foreign country): Dont Know
MAIDEN NAME OF MOTHER: Mattie T. Caldwell
BIRTHPLACE OF MOTHER (City or town, State or foreign country): dont Know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Wm Wales

(ADDRESS) New London Mo

Filed Dec 20, 1918. J. H. Gowdel REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct 24, 1918 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from only Md. I saw last in (1-8 months) ago, and that I last saw her alive on ____, 191__, and that death occurred, on the date stated above, at ____ m. at the time she died

The CAUSE OF DEATH* was as follows: not know what died had enlargement of liver also trouble of valves of Heart is all I know of the cause (Duration) ____ yrs. ____ mos. ____ ds.

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

(Signed) W B Hendrix M. D.

Oct 24, 1918 (Address) New London 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: Barclay

DATE OF BURIAL: 10/26, 1918

UNDERTAKER: H W Copson

ADDRESS: New London Mo

PLACE OF DEATH

County .....

Township ..... Registrat
or
Village ..... Primary
or
City ..... (NO. .....

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

..... 1
(Month) (Day)

AGE

..... yrs. ..... mos. ..... ds.

If I d or

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

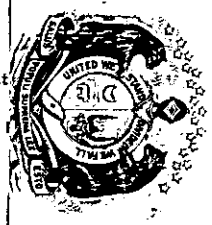
BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191....., ...
REGISTRAR



Missouri Senate
50 General Assembly

VON MAYES
CHAIRMAN
COMMITTEE ON
RAILROAD AND INTERNAL IMP

...OURI STATE BOARD OF HEALTH
...BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

..... File No. .....

..... Registered No. .....

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

...ICAL CERTIFICATE OF DEATH

....., 191.....
(Month) (Day) (Year)

...BY CERTIFY, that I attended deceased from
....., 191....., to ....., 191.....,
.....alive on ....., 191.....,
...ccurred, on the date stated above, at .....m.
...DEATH* was as follows:

.....

.....

.....

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

.....

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

..... M. D.

.....1..... (Address) .....

...Causing Death, or, in deaths from Violent Causes, state ...d (2) whether Accidental, Suicidal, or Homicidal.

...ENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR

.....mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

...contracted ...death? .....

.....

...L OR REMOVAL

DATE OF BURIAL
..... 191.....

ADDRESS

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 import...