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

1 PLACE OF DEATH

County Cape Gir.

Township ..... or Village ..... or City Cape Girardeau (NO. ..... St.; ..... Ward)

Registration District No. 126 File No. 257 494

Primary Registration District No. 3009 Registered No. .....

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

2 FULL NAME Mary Abernathy

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	Black	Married

6 DATE OF BIRTH: Dont Know (Month) ..... (Day) 1 (Year)

7 AGE: 76 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housework 82A
(b) General nature of industry, business, or establishment in which employed (or employer): 82C

9 BIRTHPLACE (City or town, State or foreign country): Cape Gir. Co.

PARENTS

10 NAME OF FATHER: Isaac Harbester

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Scott Co

12 MAIDEN NAME OF MOTHER: Henrietta Harbester

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Don't Know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mr. Abernathy
(Address) Cape Gir. Mo

15 Filed 1/11 1919. [illegible] Registrar

16 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan. (Month) 9 (Day), 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Dec 20, 1918, to Jan 9, 1919, that I last saw her alive on Jan 6, 1919, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

1 Apoplexy

(Duration) 2 yrs. 6 mos. 3 ds.

CONTRIBUTORY (Secondary) Paralysis

(Duration) ..... yrs. 1 mos. 3 ds.

(Signed) [illegible] M. D.

1/11, 1919. (Address) [illegible]

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 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

19 PLACE OF BURIAL OR REMOVAL: Harmonsurt — DATE OF BURIAL: 1-11, 1919

20 UNDERTAKER: Brinkopf Und. Co — ADDRESS: Cape Gir. Mo.

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

1 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 a hospital or institution, give its NAME instead of street and number.]

2FULL NAME.....

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day) ....., 1..... (Year)

7 AGE

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

If LESS than 1 day,.....hrs. or.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work.....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address).....

15

Filed....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

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

17 I HEREBY CERTIFY, that I attended deceased fror.....,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.

18 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.....

19 PLACE OF BURIAL OR REMOVAL | **DATE OF BURIAL** ....., 191.....

20 UNDERTAKER | **ADDRESS**