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

794

1 PLACE OF DEATH

County: Dade

Township: Dade Twp. or Village: or City: Greenfield (NO. ..... St.: ..... Ward)

Registration District No. 7137 File No.

Primary Registration District No. 4104 Registered No.

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

2 FULL NAME Emma Brown

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

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

6 DATE OF BIRTH: May 18, 1843 (Month) (Day) (Year)

7 AGE: 96 yrs. 8 mos. 3 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): North Carolina

PARENTS

10 NAME OF FATHER: [illegible]

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): [illegible]
(Address): [illegible]

15 Filed: January 7, 1919, [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH ✓

16 DATE OF DEATH: Jan. 7 (Month) (Day), 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov. 20, 1918, to January 21, 1919, that I last saw him alive on January 21st, 1919, and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Senile Debility
11B
11.2

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary): Influenza
(Duration) yrs. mos. ds.

(Signed) O. T. Wharton M. D.
January 21, 1919 (Address) Greenfield Mo.

*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: [illegible] DATE OF BURIAL: [illegible], 1919

20 UNDERTAKER: [illegible] ADDRESS: [illegible]

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

1 PLACE OF DEATH

County Dade

Township Center
or
Village
or
City Greenfield

Registration District No. 2137 File No.

Primary Registration District No. 4144 Registered No.

(NO. St.; Ward)

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

2 FULL NAME Andy M Everett

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): married

6 DATE OF BIRTH: Jany (Month) 22 (Day) 1840 (Year)

7 AGE: 79 yrs. mos. 2 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) Jay Everett

(Address) Greenfield Mo

15 Filed Jany 24, 1919 Hng Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jany (Month) 24 (Day) 1919 (Year)

17 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.

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

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.