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.

MARTIN-TERRILL, TIPTON, MO. PRINTING—THIS IS A PERMANENT RECORD

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

PLACE OF DEATH

County Nodaway

Township ~~Clearmont~~

or

Village

or

City Clearmont (No. ____, ____ St.; ____ Ward)

Registration District No. 619 File No. 25160158

Primary Registration District No. 4370 Registered No. 619

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

FULL NAME Hester Pence

PERSONAL AND STATISTICAL PARTICULARS

SEX: F

COLOR OR RACE: W

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

DATE OF BIRTH: July (Month) 14 (Day), 1890 (Year)

AGE: 28 yrs. 6 mos. 9 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): Nebraska

PARENTS
NAME OF FATHER: N G Domel
BIRTHPLACE OF FATHER (City or town, State or foreign country): Iowa
MAIDEN NAME OF MOTHER: Sarah Cordelia Griffith
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Illinois

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Otis Pence

(ADDRESS) Clearmont, Mo.

Filed Jany 24, 1919. T J Rogers REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Jan (Month) 23 (Day), 1919 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 22, 1919, to Jan 23, 1919, that I last saw her alive on Jan 23, 1919, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Puerperal Eclampsia

146 138 12 hours
(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY) Uremic Poison
Nephritis (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W M Wiley M. D.

Jan 23, 1919 (Address) Clearmont, 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: Clearmont Mo

DATE OF BURIAL: Jan 26 1919

UNDERTAKER: J W Bainwoodin

ADDRESS: Burlington Mo

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

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]

FULL 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.

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

..... , *1*.....
(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)

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

....., *191*.....
(Month) (Day) (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**