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 Marion

Township ~~[illegible]~~ Registration District No. 547 File No. 14568

or

Village Primary Registration District No. 3029 Registered No. 122

or

City Hannibal (NO. 1328 Grace St.; Ward)

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

2 FULL NAME Ruth Davis Watson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Oct. (Month) 11 (Day) 1842 (Year)

7 AGE 76 yrs. 6 mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.?

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

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

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

PARENTS

10 NAME OF FATHER John Davis

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

12 MAIDEN NAME OF MOTHER Mary Tingle

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas E. Watson

(Address) Hannibal Mo

15 Filed Apr 15 1919 F B Morris Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April (Month) 13 (Day), 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from March 13, 1919, to April 13, 1919, that I last saw her alive on April 12, 1919, and that death occurred, on the date stated above, at 4:45 A.m.

The CAUSE OF DEATH* was as follows:

10 Senility

11A

112

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

CONTRIBUTORY (Secondary) La Grippe

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

(Signed) C E Paxon M. D.

4/14, 1919 (Address) Hannibal 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 Mt. Olivet DATE OF BURIAL April 15, 1919

20 UNDERTAKER Wm M. [illegible] ADDRESS Hannibal Mo

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

1 PLACE OF DEATH

County .....

Township ..... or Village ..... or City ..... (NO. ....., ... St.; ..... Ward)

Registration District No. ..... File No. .....

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

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

2 FULL NAME .....

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

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

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