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 Warren

or

Village

or

City (NO. , St.; Ward)

Registration District No. 552 File No. 20176

Primary Registration District No. 5745 Registered No.

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

2 FULL NAME George Horace Pope

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: Aug. (Month) 11 (Day), 1826 (Year)

7 AGE: 92 yrs. 10 mos. 15 ds. If LESS than 1 day, ...hrs. or ....min.?

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

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

PARENTS

10 NAME OF FATHER: Fortunatus Pope

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

12 MAIDEN NAME OF MOTHER: Fausis Percel

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Byron Pope

(Address) Emden Mo.

15 Filed July 1st 1919 Luk Davis Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 26 (Day), 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from June 21, 1919, to June 26, 1919, that I last saw him alive on June 21, 1919, and that death occurred, on the date stated above, at 3 A.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

99 81 (Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Gregory DeLaney M. D.

June 27, 1919 (Address) Emden

*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: Davis Cemetery

DATE OF BURIAL: 6-27, 1919

20 UNDERTAKER: B. M. Allen

ADDRESS: Phila M.

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.]

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**

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

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