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

1 PLACE OF DEATH

County Shelby Co.

Township Salt Rim

or

Village

or

City ~~Shelbina~~ (NO. ..... St.; ..... Ward)

Registration District No. 830 File No. 29320

Primary Registration District No. 6091 Registered No. .....

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

2 FULL NAME Mrs Mary Ann Tinney

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: Oct (Month) 13 (Day) 1836 (Year)

7 AGE: 82 yrs. 10 mos. 21 ds.

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

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

9 BIRTHPLACE (City or town, State or foreign country): Shelby Co Mo

PARENTS

10 NAME OF FATHER: James Blackford

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

12 MAIDEN NAME OF MOTHER: Eliza Werdman

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Irene Doctor

(Address) Shelbina Mo

15 Filed Sept 4, 1919 Mitti Clay Registrar

MEDICAL CERTIFICATE OF DEATH

2

16 DATE OF DEATH: Sept (Month) 3 (Day) 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 2, 1919, to Sept 3, 1919, that I last saw her alive on Sept 3, 1919, and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

116 / 1081 O/W

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

CONTRIBUTORY (Secondary) Influenza

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

(Signed) H. C. Vaughn M. D.

Sept 5, 1919 (Address) Shelbina 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: Gillcrease Cem

DATE OF BURIAL: Sept 4, 1919

20 UNDERTAKER: Ezra Peter

ADDRESS: Shelbina

MISSOURI STATE BOARD OF H
BUREAU OF VITAL STATISTIC
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 hospital give its of street

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)

17 I HEREBY CERTIFY, that I attended dec

....., 191....., to .....

that I last saw h.....alive on .....

and that death occurred, on the date stated above, at...

The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

CONTRIBUTORY .....
(Secondary)

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

(Signed) .....

....., 191..... (Address) .....

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, T or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mo

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIA

20 UNDERTAKER | ADDRESS