LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH Noel Mo

County McDonald

Township or Village Elk River or Noel

City ..... (NO ..... St. ..... Ward)

Registration District No. 1149 File No. 33624 a

Primary Registration District No. 1696 Registered No. .....

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

2 FULL NAME Marie Madgeline Wylie

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 July (Month) 25 (Day) 1896 (Year)

7 AGE 25 yrs. 3 mos. 11 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) Hale Mo

PARENTS

10 NAME OF FATHER Asher Murpheigh

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

12 MAIDEN NAME OF MOTHER Elizabeth Kirby

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Don't Know

I THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Glenn Wylie

(Address) Noel Mo

15 Nov 8 1919 O J Jones Registrar

9 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov (Month) 5 (Day) 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov 3 1919, to Nov 5 1919, that I last saw her alive on Nov 5 1919, and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Nervous Prostration
Had to wean last Child
at 6 Months old

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

CONTRIBUTORY (Secondary) over work and Bearing Children to last two (Duration) yrs. 6 mos. ..... ds.

(Signed) G. F. Rogers M. D.

Nov 11 1919 (Address) Noel 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 Noel Mo

19 PLACE OF BURIAL OR REMOVAL Noel Mo

DATE OF BURIAL Nov 6 1919

20 UNDERTAKER Marshall Gatum

ADDRESS Noel Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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 hospital or institutio give its NAME inste 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

....., 1..... (Month) (Day) (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

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

17 I HEREBY CERTIFY, that I attended deceased fro

....., 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, sta (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicida

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

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

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**