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

34971

1 PLACE OF DEATH

County Shelby

Township ..... Registration District No. 830 File No. 42

or

Village ..... Primary Registration District No. ~~6691~~ 4503 Registered No. .....

or

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

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

2 FULL NAME Mary Ellen Frye

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. 1 (Month) — (Day), 1839 (Year)

7 AGE: 80 yrs. ..... mos. 22 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): Hannah Mo

PARENTS

10 NAME OF FATHER: Lemuel Williams

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

12 MAIDEN NAME OF MOTHER: Mary Ellen Williams

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Maryland U.S.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) V P Frye

(Address) Colo Spgs. Colo

15 Filed Oct 22, 1919, Mitti Clay Registrar

3 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 11 (Month) — 22 (Day) —, 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan. 14, 1919, to Oct 18, 1919, that I last saw her alive on Oct 18, 1919, and that death occurred, on the date stated above, at 2.9 m.

The CAUSE OF DEATH* was as follows:

Chronic Paralytic, Arteriosclerosis — Immediate Cause or Condition Uremia

82D 91 (Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) 132B (Duration) ..... yrs. ..... mos. ..... ds.

8 (Signed) J. D. Smith M. D.

Oct 22, 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 4 yrs. — mos. — ds. In the State ..... yrs. ..... mos. ..... ds.

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

Former or usual residence: near Lakeman Shelby Co Mo.

19 PLACE OF BURIAL OR REMOVAL: Greenwood Cemetery

DATE OF BURIAL: Oct-23, 1919

20 UNDERTAKER: Ezra Peter

ADDRESS: Shelbina Mo

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

....., 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 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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