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

PLACE OF DEATH

County Audrain

Township ~~[illegible]~~ or Village Farber or City _____ (NO. _____ St.: _____ Ward)

Registration District No. 921 File No. 4427

Primary Registration District No. 4557 Registered No. _____

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

FULL NAME Mary E. Tarlor

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

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

DATE OF BIRTH: Apr (Month) 16 (Day), 1857 (Year)

AGE: 62 yrs. 10 mos. 1 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

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

BIRTHPLACE (City or town, State or foreign country): Lincoln, Co. Mo

PARENTS

NAME OF FATHER: Thomas Ricks

BIRTHPLACE OF FATHER (City or town, State or foreign country): Dont Know

MAIDEN NAME OF MOTHER: Marth Ricks

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Lincoln Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard Taylor

(ADDRESS) Farber Mo.

Filed Mar 13, 1920 W. May REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Feb 17 (Month) 1920 (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 16, 1919, to Feb 8, 1920, that I last saw her alive on Feb 8, 1920, and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Cancer of Womb

45

(Duration) 1 yrs. 00 mos. ___ ds.

Contributory (SECONDARY) _____ (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) W. May M. D.

Mar 13, 1920 (Address) Farber Mo.

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

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? Place of Death

Former or usual residence Audrain Co. (Informant)

PLACE OF BURIAL OR REMOVAL: Farber, Mo.

DATE OF BURIAL (ADDRESS): Feb 19, 1920

UNDERTAKER: W. Maters

ADDRESS: Vandalia Mo.

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

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]

FULL NAME _____

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.

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____, 1____ (Month) (Day) (Year)

AGE _____ yrs. _____ mos. _____ ds.

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

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

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

BIRTHPLACE (City or town, State or foreign country) _____

PARENTS

NAME OF FATHER _____

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

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, 191____ (Month) (Day) (Year)

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.

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 _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	_____, 191____
UNDERTAKER	**ADDRESS**