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

File No. 26247

Registration District No. 15

Primary Registration District No. 5019

Registered No. 12

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

PLACE OF DEATH

County: Andrew

Township: Platte

or Village:

or City: (NO. St.: Ward)

FULL NAME Rebecca Ann Gilbert

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): married

DATE OF BIRTH: Dec 3 (Month) (Day), 1868 (Year)

AGE: 52 yrs. 7 mos. ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmers Wife
(b) General nature of industry, business, or establishment in which employed (or employer): —

BIRTHPLACE (City or town, State or foreign country): Virginia 82 PA 127 B

PARENTS
NAME OF FATHER: Leander Gilbert
BIRTHPLACE OF FATHER (City or town, State or foreign country): Kentucky
MAIDEN NAME OF MOTHER: Hobbs
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Virginia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Gilbert

(ADDRESS) Concord Mo.

Filed Sept 1, 1920. E. C. Jeffries REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Aug. 31 (Month) (Day), 1920 (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 30, 1920, to Aug 31, 1920, that I last saw her alive on Aug 31, 1920, and that death occurred, on the date stated above, at 11:20 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage

64 (Duration) — yrs. — mos. 3 ds.

Contributory (SECONDARY) Cholangitis (Duration) 5 yrs. — mos. — ds.

(Signed) A. Monroe Peter M. D.

Sep. 1 1920 (Address) Whitesville 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?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Bolcom Mo.

DATE OF BURIAL: Sep. 1 1920

UNDERTAKER: Camm

ADDRESS: Bolcom 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 .....

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

..... (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

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

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