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

28530

PLACE OF DEATH

County Texas

Township Piney, or Village ..... or City ..... (NO. ..... St.; ..... Ward)

Registration District No. 8631 File No. .....

Primary Registration District No. 6137 Registered No. 214

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

FULL NAME Emily Brower

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

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

DATE OF BIRTH: Oct (Month) 20 (Day), 1840 (Year)

AGE: 70 yrs. 9 mos. 14 ds. If LESS than 1 day, ... hrs. or ..... min.?

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

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

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BIRTHPLACE (City or town, State or foreign country): MO

PARENTS

NAME OF FATHER: Seaby

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

MAIDEN NAME OF MOTHER: unknown

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Brower

(ADDRESS) Houston, Mo.

Filed 8-15, 1920. J. W. Womack REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: 8 (Month) - 14 (Day) -, 1920 (Year)

I HEREBY CERTIFY, that I attended deceased from June 15, 1920, to Aug 14, 1920, that I last saw her alive on 2-26-, 1920, and that death occurred, on the date stated above, at 11:30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

170 (Duration) 1 yrs. ..... mos. ..... ds.

Contributory (SECONDARY) .....

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

(Signed) C. B. Blankenship M. D.

8-15-, 1920 (Address) Houston 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: Oak hill

DATE OF BURIAL: 8-15, 1920

UNDERTAKER: Floyd W. Elliott

ADDRESS: Rutledge

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.

PLACE OF DEATH

County.....

Township ..... or Village..... or City .....(NO. ..... St.: ..... Ward)

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

Registration District No. ..... File No. .....

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

[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), 1..... (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

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