LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

11273

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

1 PLACE OF DEATH

County: Shelby

Township: Salt Run

or

Village:

or

City: ~~Shelbina~~ (NO. ..., ... St., ... Ward)

Registration District No. 830 File No. 2145

Primary Registration District No. 6091 Registered No.

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

2 FULL NAME: Mrs Mary J Fowler

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 28th (Month) (Day), 1835 (Year)

7 AGE: 85 yrs. 5 mos. 12 ds. If LESS than 1 day, ... hrs. or ... min.?

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

9 BIRTHPLACE (City or town, State or foreign country): Blatensburg Ohio

PARENTS

10 NAME OF FATHER: Don't Know

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

12 MAIDEN NAME OF MOTHER: Nancy Baird

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs George R Henry

(Address) Shelbina, Mo.

15 Filed April 10 1921 Mittie Clay Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 9th (Day), 1921 (Year)

17 I HEREBY CERTIFY, that I attended deceased from April 2, 1921, to April 9, 1921, that I last saw her alive on April 8th, 1921, and that death occurred, on the date stated above, at 1:15 P. m.

The CAUSE OF DEATH* was as follows:

~~Senility~~

~~Arteriosclerosis~~

92 A Valvular lesion

97 (Duration) ... yrs. ... mos. 15 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 3 yrs. ... mos. ... ds.

(Signed) Florien Vaughn M. D.

April 11, 1921 (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 ... 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: Pepper City Ill

DATE OF BURIAL: April 11, 1921

20 UNDERTAKER: Ezra Peter

ADDRESS: Shelbina

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.

healthfulness of various pursuits can be known. The

portant. Example
29 *ds.;* *Bronchop*

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

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

..... (Month) ....., 191..... (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**

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.