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

25010

PLACE OF DEATH

County Shelby

Township ____ or Village ____ or City Shelbina (NO. ____ 4503 St.: ____ Ward)

Registration District No. 830 File No. 49

Primary Registration District No. ~~6097~~ Registered No. ____

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

FULL NAME Ida Brown Connely Miles

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

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

DATE OF BIRTH: Nov (Month), 15 (Day), 1855 (Year)

AGE: 65 yrs. 9 mos. 24 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): Newport Ky

PARENTS
NAME OF FATHER: Arthur Connely
BIRTHPLACE OF FATHER (City or town, State or foreign country): Ky
MAIDEN NAME OF MOTHER: Margret Hawthorn
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Virginia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C Cliff Miles

(ADDRESS) Shelbina mo

Filed Oct. 7, 1921. Madge Gooch REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Sept 9 (Month) (Day), 1921 (Year)

I HEREBY CERTIFY, that I attended deceased from June 8, 1921, to Sept 9, 1921, that I last saw her alive on Sept 9, 1921, and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows: Immediate Cause Peritonitis
117A
129
6
(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY) Ulceration of Stomach
(Duration) ____ yrs. ____ mos. ____ ds.

8 (Signed) J. D. Smith M. D.
9-12, 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.

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: I O O F Cem

DATE OF BURIAL: Sept 11, 1921

UNDERTAKER: E Hayes

ADDRESS: Shelbina mo

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 import

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

....., *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