

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 Gentry
Township Cooper
or
Village
or
City Stanberry (NO. R# 2)

Registration District No. 314
Primary Registration District No. 5429B

File No. 71000047
Registered No. 3

FULL NAME Harriet Hill

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

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Widowed</u>
DATE OF BIRTH <u>May</u> <u>13</u> , <u>1845</u> (Month) (Day) (Year)		
AGE <u>76</u> yrs. <u>8</u> mos. <u>12</u> ds.		IF LESS than 1 day, ____ hrs. or ____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Home</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Illinois</u>		
PARENTS	NAME OF FATHER <u>George Swearingen</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Illinois</u>	
	MAIDEN NAME OF MOTHER <u>unknown</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Illinois</u>	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Georgia L. Phillips
(ADDRESS) Stanberry

Filed Jan 27 1922 Iva E. Greenlee
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
11:30 A Jan 25, 1922
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 22, 1922, to Jan 25, 1922, that I last saw her alive on Jan 25, 1922, and that death occurred, on the date stated above, at 11:30 A.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

Contributory
(SECONDARY)

(Signed) B. E. Simpson M. D.
1/25, 1922 (Address) Stanberry, 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 Jan Mayville DATE OF BURIAL Jan 26, 1922
UNDERTAKER Remington and Co Stanberry Mo ADDRESS

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

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

PLACE OF DEATH

County _____

Township _____

or

Village _____

or

City _____

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

(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 _____ (If wife the word)

DATE OF BIRTH _____

(Month) _____ (Day) _____ (Year) _____

AGE _____

_____ yrs. _____ mos. _____ ds. _____ If LESS than 1 day, _____ hrs. _____ 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)

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 _____

19 _____

REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____

(Month) _____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____

19 _____

to _____

19 _____

that I last saw him alive on _____

19 _____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Heart disease

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

Contributory

(SECONDARY)

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

(Signed) _____

(Address) _____

M. D. _____

*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. 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 _____

19 _____

UNDERTAKER _____

ADDRESS _____