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

1 PLACE OF DEATH

County Shelby

Township ~~Blackbrook~~ or

Village or

City Shelbyville (NO. ..... St. ..... Ward)

Registration District No. 831 File No. 3425a

Primary Registration District No. 4504 Registered No. 1

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

2 FULL NAME Varandie Kaylor

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Unknown (Month) (Day) 1 (Year)

7 AGE 77 yrs. ✓ mos. ✓ ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) (County Infirmary inmate)

9 BIRTHPLACE (City or town, State or foreign country) Shelby Co. Mo.

PARENTS

10 NAME OF FATHER Kaylor

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

12 MAIDEN NAME OF MOTHER Walch

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Glenn Kaylor

(Address) Steffenville, Mo.

15

Filed June 4, 1922 Hallie Bidgood Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 25, 1922 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 23, 1922, to Jan 25, 1922, that I last saw her alive on Jan 24, 1922, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

131

129

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

9 CONTRIBUTORY (Secondary)

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

(Signed) S. H. S. Manson M. D.

Jan 25 1922 (Address) Shelbyville 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 16 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 Asbury Cemetery, Lewis Co. Mo.

DATE OF BURIAL Jan. 26, 1922

20 UNDERTAKER J. W. Thompson Son

ADDRESS Shelbyville, Mo.

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

CAUSE OF DEATH in plain terms be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state so that it may be properly classified. Exact statement of OCCUPATION is very important.