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 Ripley

Township Thomas

or

Village Torch

or

City ——— (NO. ——— St., ——— Ward)

Registration District No. 757 File No. 9901

Primary Registration District No. 5990 Registered No. 4

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

2 FULL NAME Mary Jane Raymer

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: Aug (Month) 22 (Day), 841 (Year)

7 AGE: 81 yrs. 6 mos. 20 ds. If LESS than 1 day, ✗ hrs. or ✗ min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None 1071
(b) General nature of industry business, or establishment in which employed (or employer): None 162

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

PARENTS

10 NAME OF FATHER: Ben Autry

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

12 MAIDEN NAME OF MOTHER: Sally Laeckin

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Eliza Gary

(Address) Torch Mo

15 Filed 3.17 1922 W. H. Benne Registrar

2 **MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH: March 14 (Month) (Day), 1922 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Mar 7, 1922, to Mar 14, 1922, that I last saw her alive on Mar 14, 1922, and that death occurred, on the date stated above, at 9:30 p.m.

The CAUSE OF DEATH* was as follows:

Presenility

Catarrhal Pneumonia

(Duration) ✗ yrs. ✗ mos. 28 ds.

CONTRIBUTORY (Secondary): Old age

(Duration) — yrs. — mos. — ds.

(Signed) J. M. Davidson M. D.

Mar 14, 1922 (Address) Torch 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: New Hope Cem

DATE OF BURIAL: Mar 15, 1922

20 UNDERTAKER: Minnie Gish

ADDRESS: Naylor

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 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) ..... (Day), 1..... (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) ..... (Day), 191..... (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 .....

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