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

25834

1. PLACE OF DEATH
County: Dallas — Registration District No. 241 — File No.
Township: N. Benton — Primary Registration District No. 5337 — Registered No. 127.
City ..... (No. ....., ..... St. ..... Ward)

2. FULL NAME: Mary Jones
(a) Residence. No. ..... St., ..... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: John Jones
6. DATE OF BIRTH (MONTH, DAY AND YEAR): 4-14-1884
7. AGE: Years 40 — Months — Days — If LESS than 1 day, ..... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Keeping
(b) General nature of industry, business, or establishment in which employed (or employer): Housework.
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY): Mo

PARENTS
10. NAME OF FATHER: Joe Harris
11. BIRTHPLACE (OF FATHER) (CITY OR TOWN) ..... (STATE OR COUNTRY): unknown
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY): unknown

14. INFORMANT: C. E. Reed
(Address): Plad. Mo
15. FILED 9/10, 1924 — W. A. Ashbridge, REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 9/14 1924
17. I HEREBY CERTIFY, That I attended deceased from Sept 8, 1924, to Sept 8, 1924, that I last saw her alive on Sept 14, 1924 and that death occurred, on the date stated above, at 2 P. m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis of Lungs
31 (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. ..... mos. ..... ds.
18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? at place of Death
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? none
(Signed) Frank R. Hudson, M. D.
, 19 (Address) Buffalo Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Scrimner Graveyd. — DATE OF BURIAL: 9/15 1924
20. UNDERTAKER: Jack Newport — ADDRESS: Buffalo Mo

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

**1. PLACE OF DEATH**

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No..... ..... St. .....Ward)

**2. FULL NAME** .....

(a) Residence. No..... St., .....Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) |
|---|---|---|
| | | |

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, .....hrs. or .....min. |
|---|---|---|---|---|
| | | | | |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., 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.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)..... , M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

| 19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19 |
|---|---|
| 20. UNDERTAKER | ADDRESS |

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