LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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 33626

1 PLACE OF DEATH

County Macon

Township East Valley

or

Village

or

City (NO. St.; Ward)

Registration District No. 528 File No.

Primary Registration District No. 572 Registered No.

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

2 FULL NAME Mary Kathyrene Fox

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 ~~SINGLE~~ ~~MARRIED~~ WIDOWED ~~OR DIVORCED~~ (Write the word) Widowed

6 DATE OF BIRTH Aug (Month) 20 (Day) 1845 (Year)

7 AGE 80 yrs. 2 mos. 22 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) 12-B

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

PARENTS

10 NAME OF FATHER Jess Vestel

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

12 MAIDEN NAME OF MOTHER Sarah Vestel

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Not Known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Fox

(Address) Callao Mo

15 Filed Nov. 14, 1925 W. W. Welch MD Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 13 (Month) (Day) 1925 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 30, 1925, to Nov 13, 1925, that I last saw her alive on Nov. 12, 1925, and that death occurred, on the date stated above, at 1:0 m.

The CAUSE OF DEATH* was as follows:

Cirrosis of Liver

12-B

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. W. Welch M. D.

Nov. 14, 1925 (Address) Callao 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 Old Chantaucuty DATE OF BURIAL Nov 14, 1925

20 UNDERTAKER H Leyang ADDRESS Ethel Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

..... 1.....
(Month) (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

....., 191.....
(Month) (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**

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.