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

34034

PLACE OF DEATH

County: Ripley

Township: Doniphan

or Village:

or City: " (NO. , St.; Ward)

Registration District No. 750 — File No. 7

Primary Registration District No. 5985 — Registered No. 685

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

FULL NAME Mrs. Addie Towles Thomas

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

DATE OF BIRTH: March 28, 1875 (Month) (Day) (Year)

AGE: 50 yrs. 8 mos. 10 ds. — If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION (a) Trade, profession, or particular kind of work: Home wife

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

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

PARENTS

NAME OF FATHER: J. A. Towles

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

MAIDEN NAME OF MOTHER: Elizabeth Hunington

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. N. Cuby

(ADDRESS) Doniphan, Mo.

Filed 11-18-, 1925. E. B. Johnston REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Nov. 17 (Month) (Day), 1925 (Year)

I HEREBY CERTIFY, that I attended deceased from 11/17, 1925, to 11/17, 1925, that I last saw her alive on Nov. 17, 1925 and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows: Cerebral Apoplexy

8 hr

(Duration) yrs. mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) W. V. B. Waddle M. D.

11/17, 1925 (Address) Doniphan 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 50 yrs. mos. ds. In the State 50 yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence: Doniphan, Mo.

PLACE OF BURIAL OR REMOVAL: Oakridge — DATE OF BURIAL: Nov. 19, 1925

UNDERTAKER: J. R. Wright — ADDRESS: Doniphan Mo.

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

PLACE OF DEATH

County _____

Township _____ or Village _____ or City _____ (NO. _____, _____ St.: _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[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 (*Write* the word)

DATE OF BIRTH _____ (Month) _____ (Day), 1_____ (Year)

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

PARENTS
- 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 _____, 191____, _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day), 191____ (Year)

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.

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	DATE OF BURIAL _____, 191____
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.

WRITE PLAINLY, WITH [illegible]