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

749

PLACE OF DEATH

County: Gentry

Township or Village or City: Stanberry Mo (NO. ____ St.: ____ Ward)

Registration District No. 314 File No. 1

Primary Registration District No. 4190 Registered No. 1

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

FULL NAME: Jennie W. Tandy

PERSONAL AND STATISTICAL PARTICULARS

SEX: F. COLOR OR RACE: W. SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Widow

DATE OF BIRTH: October (Month) 10 (Day), 1845 (Year)

AGE: 80 yrs. 3 mos. 5 ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

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

BIRTHPLACE (City or town, State or foreign country): Manchester Ky.

PARENTS

NAME OF FATHER: James White

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

MAIDEN NAME OF MOTHER: Mary Garrard

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Joe B. Sayer

(ADDRESS): Stanberry Mo

Filed 1-20- 1926 C S Bennett REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Jan. 15th (Month) (Day), 1926 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec. 2nd, 1925, to Jan. 14th, 1926, that I last saw her alive on Jan 14th, 1926, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

11A Pneumonia Fever with
108 Mitral Heart trouble
92A

(Duration) ____ yrs. 1 mos. 1A ds.

Contributory (SECONDARY): Flue

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

(Signed) C. H. McCaslin M. D.

____, 191__ (Address) Stanberry 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 ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? ____

Former or usual residence: Stanberry Mo

PLACE OF BURIAL OR REMOVAL: Stanberry Mo

DATE OF BURIAL: 1-17, 1926

UNDERTAKER: Laton F. Phillips

ADDRESS: Stanberry Mo

FEB 23 1926

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

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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