LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

1743

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

1 PLACE OF DEATH

County Mocon

Township Walnut
or
Village
or
City (NO. St.; Ward)

Registration District No. 530 File No. 3

Primary Registration District No. 5707 Registered No. 3

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

2 FULL NAME Sarah E Hiles

**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) 17 (Day) 1848 (Year)

7 AGE 77 yrs. 5 mos. 2 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) Ohio

PARENTS

10 NAME OF FATHER William Hamesley

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

12 MAIDEN NAME OF MOTHER Nat Known

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robt Hiles

(Address) Bucklin Mo

15 Filed Feb 2, 1926 Minnie Hoyt Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH June (Month) 19 (Day) 1926 (Year)

17 I HEREBY CERTIFY, that I attended deceased from June, 1924, to June 19, 1926

that I last saw her alive on Jan 18, 1926

and that death occurred, on the date stated above, at 3:30 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Brights

131

102

129a

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile &c

(Duration) yrs. mos. ds.

(Signed) [signature] M. D.

, 191 (Address) Ethel 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

FEB 23 1926

19 PLACE OF BURIAL OR REMOVAL Glasgow

DATE OF BURIAL Jan 21, 1926

20 UNDERTAKER [signature]

ADDRESS Ethel Mo

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.

# 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.