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

PLACE OF DEATH

County Clinton

Township Shoal

or

Village

or

City Cameron

Registration District No. 204 File No. 28797

Primary Registration District No. 3013 Registered No. 42

(NO. ____ St.; ____ Ward)

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

FULL NAME Alice Holaday

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Widow

DATE OF BIRTH Jan (Month) 13 (Day), 1848 (Year)

AGE 66 yrs. 8 mos. 15 ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

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

BIRTHPLACE (City or town, State or foreign country) Ohio

PARENTS

NAME OF FATHER Geo. Frazier

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

MAIDEN NAME OF MOTHER Sarah Elliott

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. W. Holaday

(ADDRESS) Cameron, Mo

Filed Sept 28 1914. O. C. Stribling REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept. (Month) 28 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Sept. 24, 1914, to Sept 28, 1914, that I last saw her alive on Sept 28, 1914, and that death occurred, on the date stated above, at 9.46 a.m.

The CAUSE OF DEATH* was as follows:

Obstructed Bowel

1228

(Duration) 10 yrs. 7 mos. 7 ds.

Contributory (SECONDARY) ——

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

(Signed) J. O. Bowman M. D.

Sept 28 1914 (Address) Cameron, 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

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Smith Cemetery	9/29 1914
UNDERTAKER	**ADDRESS**
For W. M. Conner	Edgerton

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

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 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

_____, 1_____
(Month) (Day) (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

_____, 19_____
(Month) (Day) (Y

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_____

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____(Duration)_____yrs._____mos._____

Contributory_____
(SECONDARY)

_____(Duration)_____yrs._____mos._____

(Signed)_____

_____, 191_____ (Address)_____

*State the Disease Causing Death, or, in deaths from Violent Causes, (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, RECENT RESIDENTS)

At place of death_____yrs._____mos._____ds. In the State_____yrs._____mos._____

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

Former or usual residence_____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	_____, 19
UNDERTAKER	ADDRESS