

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

24910

1 PLACE OF DEATH

County Henry
Township Bearcreek
or
Village Country
or
City _____ (NO. _____ St. _____ Ward)

Registration District No. 352 File No. _____
Primary Registration District No. 54984 Registered No. 24

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

2 FULL NAME Christiana M. Hollopeter

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE MARRIED WIDOWED OR DIVORCED Widowed
(Write the word)

6 DATE OF BIRTH Aug 26-1836
(Month) (Day) (Year)

7 AGE 83 yrs. no mos. no ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work none 45C 52
(b) General nature of industry business, or establishment in which employed (or employer) ✓

9 BIRTHPLACE Clearfield County, Pa.
(City or town, State or foreign country)

PARENTS
10 NAME OF FATHER Samuel Troy
11 BIRTHPLACE OF FATHER unknown
(City or town, State or foreign country)
12 MAIDEN NAME OF MOTHER unknown
13 BIRTHPLACE OF MOTHER unknown
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nellie Hollopeter
(Address) Montrose Mo

15 Filed Aug 27, 1919 J. J. Miller
Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 26, 1919
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from May 4, 1919 to Aug 25, 1919, that I last saw her alive on Aug 26, 1919, and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of face and mouth

(Duration) 1 yrs. ✓ mos. 5 ds.

CONTRIBUTORY ✓
(Secondary) (Duration) ✓ yrs. ✓ mos. ✓ ds.

(Signed) W. Kelly M. D.
8-26-1919 (Address) La Due 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 Jays Chapple DATE OF BURIAL Aug 27, 1919

20 UNDERTAKER F. H. H. H. ADDRESS Montrose 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.

1 PLACE OF DEATH

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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 (Month) (Day) 191..... (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)

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).....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month) (Day) 191..... (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:

CONTRIBUTORY (Secondary) yrs. mos. ds. (Signed) (Duration) yrs. mos. ds. (Address) M. D.

*State the Disease Causing Death, or in death 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:z 191.....

Filed....., 191....., Registrar