

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

19256

1 PLACE OF DEATH
County Hannay

Township _____
or

Village _____
or
City Clinton Mo (NO. _____ St. _____ Ward _____)

Registration District No. 360

File No. _____

Primary Registration District No. 3015

Registered No. 147

2 FULL NAME Miss Bettie Edwards

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH May 29, 1920
(Month) (Day) (Year)

6 DATE OF BIRTH July 10, 1835
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from May 4, 1920 to May 29, 1920, that I last saw her alive on May 28, 1920, and that death occurred, on the date stated above, at 6 a m.
The CAUSE OF DEATH* was as follows:

7 AGE 84 yrs. 11 mos. 20 ds.
If LESS than 1 day, hrs. or min.?

Fractured hip
Year 13 left leg broken
1943
(Duration) yrs. mos. ds.

8 OCCUPATION
(a) Trade, profession, or particular kind of work House Keeper
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE Clinton, Missouri
(City or town, State or foreign country)

CONTRIBUTORY (Secondary) 8
(Duration) yrs. mos. ds.
(Signed) D. H. Poyner M. D.
6/1, 1920 (Address) Clinton, Mo.

10 NAME OF FATHER John Sharp

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

12 MAIDEN NAME OF MOTHER Sally Walker

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

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death yrs. mos. ds. In the State yrs. mos. ds.

(Informant) Dave Edwards

Where was disease contracted if not at place of death?

(Address) Clinton 711

Former or usual residence Clinton

15 Filed May 30, 1920 B. B. Burr Registrar

19 PLACE OF BURIAL OR REMOVAL Clinton Mo DATE OF BURIAL 5/30, 1920

20 UNDERTAKER Clinton Mo 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.

STATEMENT 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.

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1 PLACE OF DEATH
County

Township

or
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or
City

Registration District No.

Primary Registration District No.

City (NO)

Registered No.

St. Ward)

File No.

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 SINGLE
 MARRIED
 WIDOWED
 OR DIVORCED
(Write the word)

4 COLOR OR RACE

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)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
(Month), (Day), 191.. (Year)

17 I HEREBY CERTIFY, that I attended deceased from
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:

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)

CONTRIBUTORY
(Secondary), yrs. mos. ds.
(Duration), yrs. mos. ds.
(Signed), 191.. (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

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