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.

PLACE OF DEATH

County Henry

Township Windsor

or

Village

or

City (NO. St.; Ward)

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

15457

Registration District No. 14

File No.

Primary Registration District No. 4211

Registered No. 22

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

FULL NAME Mrs Mary Farmer

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Oct 21 (Month) (Day) 1862 (Year)

AGE 59 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.?

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

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

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

PARENTS

NAME OF FATHER Allen Eaketch

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

MAIDEN NAME OF MOTHER Dont Know

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Dont Know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. Farmer.

(ADDRESS) Calhoun Mo.

Filed 5-5, 1922 [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May (Month) 4th (Day) 1922 (Year)

I HEREBY CERTIFY, that I attended deceased from Apr 12, 1922, to May 4th, 1922, that I last saw her alive on May 4, 1922, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Tubercular of the Lungs

23A

(Duration) 2 yrs. 3 mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) L. A. Boland M. D.

May 5 1922 (Address) Calhoun 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 Calhoun

DATE OF BURIAL May 5 1922

UNDERTAKER Noel Butler

ADDRESS Calhoun

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

PLACE OF DEATH

County Calhoun. Mo

Township Henry County — Registration District No. ____ — File No. ____

or Village ____ — Primary Registration District No. ____ — Registered No. ____

or City ____ (NO. ____ St. ____ Ward) [If death occurred in hospital or institutic give its NAME inste of street and number]

FULL NAME Frank Smith

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH ____ (Month) ____ (Day) I____ (Year)

AGE 53 yrs. ____ mos. 20 ds. — If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Rail Road Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): ____

BIRTHPLACE (City or town, State or foreign country): mo

PARENTS

NAME OF FATHER: Geo Smith

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

MAIDEN NAME OF MOTHER: Dont Know

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Dont Know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ____

(ADDRESS) ____

Filed ____, 191__ ____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mch 3d-- 18 ____, 19__ (Month) (Day) (Yea

I HEREBY CERTIFY, that I attended deceased fr ____, 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, TRANSIENT 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
Calhoun.	Mch 20.
UNDERTAKER	**ADDRESS**
W, C. Butler	Calhoun

tributory (secondary or intercurrent) ____ be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptom-