

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

PLACE OF DEATH

County Clark
Township Union
or
Village Medill
or
City _____ (NO. _____ St.: _____ Ward)

Registration District No. 190 File No. 26823

Primary Registration District No. 5264 Registered No. 35

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

FULL NAME Marie Sells

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>
DATE OF BIRTH <u>Feb. 9, 1910</u> (Month) (Day) (Year)		
AGE <u>6 yrs. 22 mos. 22 ds.</u>		IF LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

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

PARENTS	NAME OF FATHER <u>Elijah Sells</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Clark Co.</u>
	MAIDEN NAME OF MOTHER <u>Lottie Miller</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>St. Madison Ia</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elijah Sells
(ADDRESS) Medill Mo

Filed Sept 1 1910 H. B. Sisson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 31, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 29, 1910, to Aug 31, 1910, that I last saw her alive on Aug 31, 1910, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:
Acute dysentery
13 1/2
(Duration) ___ yrs. ___ mos. 9 ds.

Contributory _____
(SECONDARY) _____
(Duration) ___ yrs. ___ mos. ___ ds.
(Signed) W. D. ... M. D.
Aug 31, 1910 (Address) Kahoka, 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 Medill Mo. DATE OF BURIAL Sept 2, 1910
UNDERTAKER J. J. Karle ADDRESS Kahoka 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.

