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 Nodaway

Township ~~Nodaway~~

or

Village

or

City Burlington Jc Mo (No. ____ St.; ____ Ward)

Registration District No. 618 File No. 23648-B

Primary Registration District No. 4369 Registered No. ____

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

FULL NAME Amanda Day

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: July 16, 1838 (Month) (Day) (Year)

AGE: 74 yrs. 10 mos. 26 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): X

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

PARENTS

NAME OF FATHER: Harrison Day

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

MAIDEN NAME OF MOTHER: Sarah Hamilton

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nancy Smith

(ADDRESS) Roseville Ill

Filed July 12, 1913 C. G. Dean REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: June 12, 1913 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 4th, 1913, to June 12th, 1913, that I last saw her alive on June 12th, 1913, and that death occurred, on the date stated above, at 12 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Inferior maxilla and tongue

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

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

(Signed) C. E. Cossins M. D.

June 14th, 1913 (Address) Burlington Jct 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: Ohio Cemetery

DATE OF BURIAL: June 14, 1913

UNDERTAKER: T. E. Fordyce

ADDRESS: Bur'l Ja Mo

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

PLACE OF DEATH

County _____

Township _____
or
Village _____
or
City _____ (NO. _____ St. _____ Ward)

MISSOURI STATE BOARD
BUREAU OF VITAL ST
CERTIFICATE OF DE

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____ (Month) _____ (Day) _____, 1_____ (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 DE

DATE OF DEATH _____ (Month)

I HEREBY CERTIFY, that I att
_____, 191____, to _____
that I last saw h_____ alive on _____
and that death occurred, on the date stat
The CAUSE OF DEATH* was as follows:

_____
_____
_____
_____ (Duration) _____ yrs.

Contributory _____
(SECONDARY)
_____ (Duration) _____ yrs.

(Signed) _____

_____, 191____ (Address) _____

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

LENGTH OF RESIDENCE (FOR HOSPITALS INSTI RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ y

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

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL | DA

UNDERTAKER | AD