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 Adair

Township or Village or City Kirksville

Registration District No. 4 — File No. 15162

Primary Registration District No. 3001 — Registered No. 191

(NO. ~~603 E Harrison~~ Grim Hospital St.: Ward)

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

FULL NAME Inez B Reynolds

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female — COLOR OR RACE: white — SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: Sept 21 (Month) (Day), 1883 (Year)

AGE: 28 yrs. 7 mos. 20 ds. — If LESS than 1 day, ___ hrs. or ___ min.?

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

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

PARENTS
NAME OF FATHER: H C Reynols
BIRTHPLACE OF FATHER (City or town, State or foreign country): Adair Co
MAIDEN NAME OF MOTHER: Sarah A Jones
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Schuyler Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sarah A Reynolds
(ADDRESS) Kirksville Mo

Filed 5 12, 1914. C W Parrish REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: May (Month) 11 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from May 1, 1914, to May 11, 1914, that I last saw her alive on May 10, 1914, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Appendicitis

1918

(Duration) 108 yrs. ___ mos. 24 ds.

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

(Signed) E. A. Grim M. D.
May 12, 1914 (Address) Kirksville 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. 3 ds. In the State Life yrs. ___ mos. ___ ds.
Where was disease contracted if not at place of death? at residence
Former or usual residence 603 E Harrison St Kirksville

PLACE OF BURIAL OR REMOVAL: Forest park Cemetery — DATE OF BURIAL: May 13, 1914

UNDERTAKER: H. C. Wilson — ADDRESS: Kirksville

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

PLACE OF DEATH

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]

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

....., 1.....
(Month) (Day) (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 DEATH

DATE OF DEATH

....., 191.....
(Month) (Day). (Year)

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:

.....

.....

.....

.....(Duration).....yrs. .....mos. .....ds.

Contributory.....
(SECONDARY)

.....(Duration).....yrs. .....mos. .....ds.

(Signed)..... M. D.

....., 191..... (Address).....

*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	DATE OF BURIAL ....., 191....
UNDERTAKER	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.