V. S. No. 2.

MARGIN RESERVED FOR BINDING

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 import

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

PLACE OF DEATH

...ty Pitty

...nship Flat Creek

...ge Spring Fork

Registration District No. 668 File No. 23599

Primary Registration District No. 5891 Registered No. 184

(NO. ..... St.; ..... Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME John O'Brien

PERSONAL AND STATISTICAL PARTICULARS

...K	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Single

...TE OF BIRTH June (Month) 24 (Day) 1847 (Year)

...E 67 yrs. ..... mos. 14 ds. If LESS than 1 day, ... hrs. or ..... min.?

...UPATION (Trade, profession, or ...icular kind of work) Farmer

General nature of industry, ...ness, or establishment in ...h employed (or employer) work on farm

...THPLACE (...y or town, ...e or foreign country) Kerry Ireland

NAME OF FATHER Jno O'Brien

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

MAIDEN NAME OF MOTHER Julia Riozda

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

...ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

...ormant) Malachi O'Brien

(ADDRESS) Spring Fork R2 Dn

...d 7/10 1914 F. B. Jones REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July (Month) 9 (Day) 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from June 25, 1914, to July 7, 1914, that I last saw him alive on July 7, 1914, and that death occurred, on the date stated above, at 1:50 am. The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 7 yrs. ..... mos. ..... ds.

Contributory (SECONDARY) Don't Know

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

(Signed) M. T. Collins M. D.

7-10 1914 (Address) M. T. Collins

*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 Spring Fork

DATE OF BURIAL 7-11 1914

UNDERTAKER McLaughlin Bros

ADDRESS Sedalia

V. S. No. 2.

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

PLACE OF DEATH

County.....

Township ..... or Village..... or City .....

Registration District No.....

Primary Registration District No.....

File No.....

Registered No.....

(NO. ..... St.: ..... rd)

[If death occurr hospital or inst give its NAME of street and num

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

..... (Month) ....., 1..... (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

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

I HEREBY CERTIFY, that I attended deceased

....., 191....., to ....., 19

that I last saw h..... alive on ....., 19

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) ..... M

..... 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, Transients 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
	....., 19
UNDERTAKER	ADDRESS