LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County Monroe

Township or Village Madison or City

Registration District No. 579 File No. 42100

Primary Registration District No. ~~5776~~ 434 Registered No.

(NO. St.; Ward)

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

2 FULL NAME Lonah Tucker Chowning

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

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

6 DATE OF BIRTH Sept (Month) 16 (Day) 1847 (Year)

7 AGE 70 yrs. 2 mos. 10 ds.

If LESS than 1 day, ...hrs. or ....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry business, or establishment in which employed (or employer) X

9 BIRTHPLACE (City or town, State or foreign country) Stewartsville Missouri

PARENTS

10 NAME OF FATHER Benj. S. Tucker

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

12 MAIDEN NAME OF MOTHER Eliza Gray

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ky.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Orville Chowning

(Address) Madison Mo

15 Filed 12/8 1917 W W Eubank Deputy

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. (Month) 6th (Day) 1917 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Mar. 1917 to Dec. 6th 1917 that I last saw her alive on Dec. 6th 1917 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Non Asimulation

1.2

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. C. Lensley M. D.

Dec. 12th 1917 (Address) Madison

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 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

19 PLACE OF BURIAL OR REMOVAL [illegible]

DATE OF BURIAL Dec. 9 1917

20 UNDERTAKER [illegible]

ADDRESS

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

1 PLACE OF DEATH

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

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occur hospital or in give its NAME of street and n

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

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

7 AGE

..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

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

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

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

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

17 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) .....

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

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transi or 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 .....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

....., 19

20 UNDERTAKER

ADDRESS

Revised United States Standard Certificate of Death

"Typhoid pneumonia"; *Lobar pneumonia; Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite);