LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

Trippeer

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

7769

1 PLACE OF DEATH

County Macon

Township ~~[illegible]~~ Registration District No. 529 File No.

or Village College Mound Primary Registration District No. 4313 Registered No.

or City (NO. , St.; Ward)

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

2 FULL NAME Mary Daisy Leter

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

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

6 DATE OF BIRTH Feb 3, 1920 (Month) (Day) (Year)

7 AGE 44 yrs. 9 mos. 16 ds. If LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Macon Co.

PARENTS

10 NAME OF FATHER T. W. Overby

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Don't Know

12 MAIDEN NAME OF MOTHER Mary Ann Lunsford

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Don't Know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) May Leter
(Address) College Mound Mo

15 Filed March 17 1920 C. H. Brabson Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 3, 1920 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from February 1st 1920, to February 3, 1920, that I last saw her alive on February 2, 1920, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:
asthma & Flue
11A
112
10
asthma several years
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

8 (Signed) F. L. Trippeer M. D.
2-3, 1920 (Address) College Mound

*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 Hebron Cem DATE OF BURIAL Feb 5, 1920

20 UNDERTAKER Albert Skinner ADDRESS Macon 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.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

1 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.]

2 FULL NAME .....

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

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

6 DATE OF BIRTH

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

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

17 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.

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

DATE OF BURIAL

....., 191.....

20 UNDERTAKER

ADDRESS