LOCAL REGISTRAR'S RECORD—DO NOT TEAR

20120-5

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

Registration District No. 708 File No. A 20120-5

Primary Registration District No. 5932 Registered No. 17

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

1 PLACE OF DEATH

ty Polk

nship Johnson

ge

(NO. ..... St.; ..... Ward)

2 FULL NAME Mary Agnes Shirey

V. S. No. 2. A

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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

	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Fe	W.	Widowed

E OF BIRTH October (Month) 5 (Day) 1843 (Year)

76 yrs. 7 mos. ..... ds. — If LESS than 1 day, ... hrs. or ..... min.?

UPATION Trade, profession, or icular kind of work Housewife

General nature of industry ness, or establishment in h employed (or employer) —

THPLACE or town, or foreign country) Ind.

10 NAME OF FATHER Taylor

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

12 MAIDEN NAME OF MOTHER unknown

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

E ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

nformant) W. C. Shirey

(Address) Dunnegan Mo.

led May 7, 1920 Oliver Brown Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May (Month) 5 (Day), 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Apr 30, 1920, to May 5, 1920, that I last saw h W alive on May 5, 1920, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Acute cholecystitis

(Duration) 115 yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) .....

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

(Signed) C N Hahn M. D.

May 5, 1920 (Address) Humansville Mo.

*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 Brookline Mo. — DATE OF BURIAL May 6, 1920

20 UNDERTAKER J A Joseph — ADDRESS Humansville Mo.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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 important.

No. 2. A

1 PLACE OF DEATH

County .....

Township ..... or Village ..... or City ..... (NO. ....., ... St.; ..... Ward)

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

Registration District No. .....

Primary Registration District No. .....

File No. .....

Registered No. .....

[If death occu 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 Homi

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans 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