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

24397

1 PLACE OF DEATH

County Henry

Township or Village or City Clinton 2880 (NO. ..... St.: ..... Ward)

Registration District No. 350 File No.

Primary Registration District No. 3010 Registered No. 155

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

2 FULL NAME Nancis Ann Hearst

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: Nov 15 (Month) (Day) 1838 (Year)

7 AGE: 82 yrs. ..... mos. ..... ds.

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

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

9 BIRTHPLACE (City or town, State or foreign country): Harrod Co. Kentucky

PARENTS

10 NAME OF FATHER: James Lee

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

12 MAIDEN NAME OF MOTHER: Nancis Ann Lee

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Hearst

(Address) Clinton Mo

15 Filed July 7 1920 O. B. Rash Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 6 (Day) 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from July 1, 1920, to July 6, 1920, that I last saw h... alive on July 3, 1920, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

(a) Paralysis of right side
Cerebral Hemorrhage
Heart failure

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

CONTRIBUTORY (Secondary) .....

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

(Signed) D. A. Pogue M. D.

7/10, 1920 (Address) Clinton 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: Bethel Cem

DATE OF BURIAL: July 7 1920

20 UNDERTAKER: Sims & Walker

ADDRESS: Clinton

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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.]

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

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..... (Year)

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

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.