

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.

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

PLACE OF DEATH  
County Barry  
Township Cappadocia Registration District No. 30 File No. 23581  
or  
Village \_\_\_\_\_ Primary Registration District No. 5041 Registered No. 76  
or  
City Monett Mo (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

FULL NAME Martin Flaherty

**PERSONAL AND STATISTICAL PARTICULARS**

SEX Male COLOR OF RACE White SINGLE MARRIED WIDOWED OR DIVORCED Mar.  
(Write the word)  
DATE OF BIRTH November 10, 1837  
(Month) (Day) (Year)

AGE 78 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

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

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

PARENTS  
NAME OF FATHER Michael Flaherty  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ireland  
MAIDEN NAME OF MOTHER Delia Joyce  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ireland

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Mary Flaherty  
(ADDRESS) Monett Mo

Filed July 31 1916 J. H. M. [Signature] REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH July 30, 1916  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 30, 1916, to July 30, 1916, that I last saw him alive on July 28th, 1916, and that death occurred, on the date stated above, at 2:45 p. m. The CAUSE OF DEATH\* was as follows:

Heart  
Caused by Liver  
Have no idea as to the  
were no definite symptoms  
Contributory 3 months before death  
(SECONDARY) (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) H. R. [Signature] M. D.  
July 31, 1916 (Address) Peire City Mo

\*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 40 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the 40 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted if not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL Peire City DATE OF BURIAL Aug 1 1916  
UNDERTAKER Curley ADDRESS Curdy Mo

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

County.....  
 Township..... or..... File No.....  
 Village..... or..... Primary Registration District No..... Registered No.....  
 City..... (NO.....)..... St..... Ward.....  
 [If death occurred in a hospital or institution, give its NAME instead of street and number]

<b>FULL NAME</b>		<b>MEDICAL CERTIFICATE OF DEATH</b>	
<b>PERSONAL AND STATISTICAL PARTICULARS</b>		<b>DATE OF DEATH</b>	
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (If tick the word)	....., 191....., 191..... (Month) (Day) (Year)
DATE OF BIRTH	AGE	....., 191....., to....., 191..... (Month) (Day) (Year)	<b>I HEREBY CERTIFY, that I attended deceased from</b> ....., 191....., to....., 191..... that I last saw h..... alive on....., 191..... and that death occurred, on the date stated above, at..... <b>The CAUSE OF DEATH* was as follows:</b>
OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)		(Signed)..... (Duration)..... yrs..... mos..... ds. (Secondary)..... (Duration)..... yrs..... mos..... ds. M. D.	
BIRTHPLACE (City or town, State or foreign country) NAME OF FATHER BIRTHPLACE (City or town, State or foreign country) MAIDEN NAME OF MOTHER BIRTHPLACE (City or town, State or foreign country)		* 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. State..... yrs..... mos..... ds. Where was disease contracted if not at place of death? Former or usual residence.....	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant)		PLACE OF BURIAL OR REMOVAL DATE OF BURIAL	
(ADDRESS)		UNDERTAKER ADDRESS	
Filed..... 191.....		REGISTRAR	