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.

PLACE OF DEATH

County Newton

Township Neosho or Village

City (NO. St.; Ward)

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

Registration District No. 610 File No. 38970

Primary Registration District No. 5811 Registered No.

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

FULL NAME Nancy J West

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	W.

DATE OF BIRTH Feb 10, 1828 (Month) (Day) (Year)

AGE 89 yrs. 9 mos. 4 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work housewife 1864
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Robertson Co Tenn

PARENTS

NAME OF FATHER Boyd

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

MAIDEN NAME OF MOTHER unknown

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J B West

(ADDRESS) Neosho Mo

Filed Nov 22, 1917. J B Hancock, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov 16 (Month) (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from August 15, 1917, to Nov 16th, 1917, that I last saw h. alive on Nov 16th, 1917, and that death occurred, on the date stated above, at 1 3/4 m.

The CAUSE OF DEATH* was as follows:

Old age or Senility

(Duration) yrs. 3 mos. ds.

Contributory (SECONDARY) Fall accidental

(Duration) yrs. mos. 3 ds.

(Signed) S A Russell M. D.

Nov 19th 1917 (Address) Fairview 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 yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Int Pine Church	Nov 17 1917
UNDERTAKER	**ADDRESS**
White & Payne	Fairview

PLACE OF DEATH

County _____

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

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

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occur hospital or ins give its NAME of street and nu

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

_____, _____, _____
(Month) (Day) (Year)

AGE

_____ yrs. _____ mos. _____ ds.

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

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

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

MAIDEN NAME OF MOTHER

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____, _____
(Month) (Day)

I HEREBY CERTIFY, that I attended deceased

_____, 191____, to _____,

that I last saw h____ alive on _____,

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 Caus (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIE 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 _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
UNDERTAKER	**ADDRESS**

Revised United States Standard Certificate of Death

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