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 McDonald

Township Buffalo or Village ______ or City ______ (NO. ______ St.; ______ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

Registration District No. 923

Primary Registration District No. 5689

File No. 5727-a

Registered No. ______

FULL NAME Martha Ellen Vermillion

PERSONAL AND STATISTICAL PARTICULARS		
SEX: Female	COLOR OR RACE: white	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married
DATE OF BIRTH: Aug (Month) 14 (Day), 1860 (Year)		
AGE: 57 yrs. 6 mos. 21 ds.	If LESS than 1 day, ___ hrs. or ___ min.?	
OCCUPATION (a) Trade, profession, or particular kind of work: House wife		
(b) General nature of industry, business, or establishment in which employed (or employer): —		
BIRTHPLACE (City or town, State or foreign country): Illinois		
PARENTS — NAME OF FATHER: Robert Harris		
BIRTHPLACE OF FATHER (City or town, State or foreign country): ~~Pennsylvania~~ Tenn		
MAIDEN NAME OF MOTHER: Don't Know		
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Don't Know		

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. M. Vermillion

(ADDRESS) Seneca RFD #1.

Filed Feb. 22, 1918 W. M. Campbell John Phillips REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb (Month) 21 (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from —, 191—, to —, 191—, that I last saw her alive on —, 191—, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Accidental (Killed by horse) Charles Leader and C. B. Yocum found her dead & removed the horse which had fallen upon her (Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) 21 F 190 (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) R. B. Donnelly, M. D.

Feb 22, 1918 (Address) Seneca 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
Baptist Cemetery	Feb 22, 1918

UNDERTAKER	ADDRESS
B. W. Buzzard	Seneca Mo

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 ____

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

Registration District No. ____ File No. ____

Primary Registration District No. ____ Registered No. ____

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

FULL NAME ____

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH ____ (Month) ____ (Day) ____, 1 ____ (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), 191 ____ (Year)

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.

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 ____, 191 ____

UNDERTAKER ____ ADDRESS ____