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

28948

PLACE OF DEATH

County Jay

Township Camden or Village ____ or City ____ Registration District No. 739 Primary Registration District No. 3429 File No. ____ Registered No. ____

(NO. ____ St. ____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Mrs Celia Crowley

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female | COLOR OR RACE: Black | SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: ____ (Month) ____ (Day) 1 (Year)

AGE: 66 yrs. 6 mos. 16 ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE (City or town, State or foreign country): Near Richmond Mo

PARENTS
NAME OF FATHER: Geo. McGill
BIRTHPLACE OF FATHER (City or town, State or foreign country): D. K.
MAIDEN NAME OF MOTHER: D. K.
BIRTHPLACE OF MOTHER (City or town, State or foreign country): D. K.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jack Crowley

(ADDRESS) Camden Mo

Filed Aug 24 1916 W. M. Burgess REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: August (Month) 23 (Day) 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from May 6, 1916, to July 7, 1916, that I last saw h[er] alive on July 7, 1916, and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency & Right side of heart. or Hydrothorax 79

(Duration) 75 D yrs. ____ mos. ____ ds.

Contributory (SECONDARY) ____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) G. W. Smith M. D.

Aug. 24, 1916 (Address) Henrietta 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: Camden Cem. DATE OF BURIAL: Aug 24. 1916

UNDERTAKER: W. M. Burgess ADDRESS: Camden Mo

PLACE OF DEATH

County.....

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

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

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

....., 191.....
(Month) (Day) (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

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

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