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 Ray Co mo

Township _____ or Village _____ or City Richmond Mo (No. _____ St.; _____ Ward)

Registration District No. 744 File No. 27490

Primary Registration District No. 3035 Registered No. 171

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

FULL NAME Amandy Jacobs

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	~~SINGLE~~ ~~MARRIED~~ WIDOWED ~~OR DIVORCED~~ (Write the word)
Female	Black	Widowed

DATE OF BIRTH: Oct 29 (Month), (Day), 1853 (Year)

AGE: 59 yrs. 9 mos. 5 ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE (City or town, State or foreign country): Ray Co Mo

PARENTS

NAME OF FATHER: Jacob Brigman

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

MAIDEN NAME OF MOTHER: Mahalby Brigman nee

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ollie Wright

(ADDRESS) Richmond Mo

Filed Aug 6 1913. Geo M Hunt Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Aug (Month) 5th (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 1st, 1913, to Aug 5th, 1913, that I last saw h.e alive on Aug 4, 1913, and that death occurred, on the date stated above, at 12 30 A. m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

9 V F

(Duration) 3 yrs. ____ mos. ____ ds.

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

(Signed) R Servier M. D.

Aug 5 1913. (Address) Richmond 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
City Cemetery	Aug 6 1913
UNDERTAKER	**ADDRESS**
Hunnell & Co	Richmond Mo

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE 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]

FULL NAME_____

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

_____, *1*_____
(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

_____, *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

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.

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