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

Township: ~~Richmond~~ — Registration District No. 744 — File No. 28957

or Village — Primary Registration District No. 3035 — Registered No. 472

or City: Richmond (No. ______ St.; ______ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Mary A. Noblitt

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH: Don't Know, 1835 (Month) (Day) (Year)

AGE: 81 yrs. don't know 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): Ray Co. Mo.

PARENTS

NAME OF FATHER: John Scone

BIRTHPLACE OF FATHER (City or town, State or foreign country): Don't Know

MAIDEN NAME OF MOTHER: Racheal Remley

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. B. Remley
By A W Manson

(ADDRESS) Orrick Mo. R.F.D.

Filed Aug 23 1916. Geo W. Hunt, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from March 20, 1916, to Aug. 23, 1916, that I last saw her alive on Aug. 19, 1916, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Old age and senility, 154

135B
162

(Duration) ______ yrs. 6 mos. ______ ds.

Contributory (SECONDARY) Cystitis,

(Duration) ______ yrs. ______ mos. ______ ds.

(Signed) J. B. Cook M. D.

Aug. 23, 1916 (Address) Rayville, 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
Smith Cemetery	8/23, 1916

UNDERTAKER	ADDRESS
A W Manson	Richmond Mo.

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 ______ Registration District No. ______ [illegible] 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			MEDICAL CERTIFICATE OF DEATH
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)	DATE OF DEATH ______ (Month) ______ (Day), 191__ (Year)
DATE OF BIRTH ______ (Month) ______ (Day), 1__ (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.
AGE ______ yrs. ______ mos. ______ ds.	If LESS than 1 day, ___ hrs. or ___ min.?		The CAUSE OF DEATH* was as follows:
OCCUPATION (a) Trade, profession, or particular kind of work ______			______ (Duration) ______ yrs. ______ mos. ______ ds.
(b) General nature of industry, business, or establishment in which employed (or employer) ______			Contributory ______ (SECONDARY) ______ (Duration) ______ yrs. ______ mos. ______ ds.
BIRTHPLACE (City or town, State or foreign country) ______			(Signed) ______ M. D.
PARENTS: NAME OF FATHER ______			______, 191__ (Address) ______
BIRTHPLACE OF FATHER (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.
MAIDEN NAME OF MOTHER ______			LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
BIRTHPLACE OF MOTHER (City or town, State or foreign country) ______			At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			Where was disease contracted if not at place of death? ______
(Informant) ______			Former or usual residence ______
(ADDRESS) ______			PLACE OF BURIAL OR REMOVAL ______ DATE OF BURIAL ______, 191__
Filed ______, 191__, ______ REGISTRAR			UNDERTAKER ______ ADDRESS ______