MARGIN RESERVED FOR BINDING
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 Camden | Registration District No. 735 | File No. 19628

or Village | Primary Registration District No. 5974 | 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 Maggie Ed Profitt

PERSONAL AND STATISTICAL PARTICULARS		
SEX: Female	COLOR OR RACE: White	SINGLE MARRIED ✗ WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH: Aug 8th, 1869 (Month) (Day) (Year)		
AGE: 47 yrs. 9 mos. 10 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): Madison Co. Ky.		
PARENTS — NAME OF FATHER: Wm Ogg		
BIRTHPLACE OF FATHER (City or town, State or foreign country): Madison Co. Ky.		
MAIDEN NAME OF MOTHER: M. E. Duerson		
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ky.		

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. F. Campbell

(ADDRESS) Orrick Mo.

Filed May 18 1917 W. W. Burgess REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May (Month) 18 (Day), 1917 (Year) 3 p.m.

I HEREBY CERTIFY, that I attended deceased from May 11, 1917, to May 17, 1917, that I last saw her alive on May 17, 1917, and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Progressive Pernicious Anaemia - Primary Cause of disease Slip of Spine - Curvature of ... [illegible]

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

Contributory (SECONDARY) 54

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

(Signed) Dr. H. E. Cheatham M.D.

May 21 1917 (Address) Excelsior Spgs, 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
South Point	May 19, 1917
UNDERTAKER: W. W. Burgess	ADDRESS: Camden

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

PLACE 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 .....

WHITE 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.

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