

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 Sullivan

Township Bourmar

or Village _____

or City _____ (NO. _____ St.: _____ Ward)

Registration District No. 854

File No. 112129

Primary Registration District No. 6118B

Registered No. Two

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

FULL NAME Rachel A Dewitt

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH May 7, 1873
(Month) (Day) (Year)

AGE 88 yrs. 9 mos. 17 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) 9-9

BIRTHPLACE (City or town, State or foreign country) Stubensville Ohio

PARENTS
NAME OF FATHER Joseph Mairo
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ireland
MAIDEN NAME OF MOTHER Margaret Bell
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Jefferson Co Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W H Dewitt

(ADDRESS) Reger Mo

Filed Feb 1, 1912 B J Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 26, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 24, 1912, to Feb 26, 1912, that I last saw her alive on Feb 26, 1912, and that death occurred, on the date stated above, at 2:25 p.m.

The CAUSE OF DEATH was as follows:
Double Pneumonia
108
(Duration) 9 yrs. ___ mos. ___ ds.

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

(Signed) J D Hummel M. D.
Feb 26, 1912 (Address) Reger 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 Stony Cemetery DATE OF BURIAL Feb 28, 1912
UNDERTAKER C A Schone ADDRESS McLean 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**

County _____

Township _____ File No. _____

or Village _____ 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 _____ | (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) _____ | |

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, 191____ (Month) _____, 191____ (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) _____, 191____ (Address) _____ M. D.

*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. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____

REGISTRAR

| | |
|----------------------------------|-------------------------------|
| PLACE OF BURIAL OR REMOVAL _____ | DATE OF BURIAL _____, 191____ |
| UNDERTAKER _____ | ADDRESS _____ |