

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 Candeur Registration District No. 739 File No. 28948  
or  
Village \_\_\_\_\_ Primary Registration District No. 45974 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 Mrs Celia Cowley

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE Black SINGLE MARRIED Married WIDOWED OR DIVORCED (If file the word)

DATE OF BIRTH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (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 House Wife  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

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

NAME OF FATHER Geo. M. Gill

BIRTHPLACE OF FATHER (City or town, State or foreign country) D.K.

MAIDEN NAME OF MOTHER D. H.

BIRTHPLACE OF MOTHER (City or town, State or foreign country) D. A.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jack Cowley

(ADDRESS) Candeur Mo

Filed Aug 24 1916 W. M. Boyer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from May 6, 1916, to July 7, 1916, that I last saw her 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 of Right side of heart, of Hydrothorax  
95 B (Duration) yrs. mos. ds.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) yrs. mos. ds.

(Signed) E. 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 Candeur Cem. DATE OF BURIAL Aug 24, 1916

UNDERTAKER W. M. Boyer ADDRESS Candeur Mo

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

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

County.....  
Township.....  
or  
Village.....  
or  
City.....

Registration District No. ....  
Primary Registration District No. ....  
St. .... Ward) .....  
City (NO .....  
Township.....  
or  
Village.....  
or  
City.....

File 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<br>MARRIED<br>WIDOWED<br>OR DIVORCED<br>(Write the word) |
| DATE OF BIRTH | (Month) .....                 | (Day) .....   |
| AGE           | ..... yrs. .... mos. .... ds. | IF LESS than<br>1 day, ..... hrs.<br>or ..... min. P            |

**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).....

**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) ....., 191..... (Day) ....., 191..... (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<sup>†</sup> was as follows:**

**Contributory**  
(SECONDARY)  
(Signed)....., 191..... (Address)....., M. D.

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

\*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**  
....., 191.....

**DATE OF BURIAL**  
....., 191.....

**UNDERTAKER**  
.....

**ADDRESS**  
.....