

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

1 PLACE OF DEATH

County Ray
Township Knoxville
or
Village
or
City

Registration District No. 915 File No. 52237
Primary Registration District No. 6236 Registered No. 8
(NO. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mary Ann Gorham

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

3 SEX Female 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED Widow.
(Write the word)

16 DATE OF DEATH Sept 5, 1922
(Month) (Day) (Year)

6 DATE OF BIRTH Sept 8, 1837
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 7, 1921, to Sept 5, 1922 that I last saw her alive on Sept 5, 1922 and that death occurred, on the date stated above, at 6 a.m.

7 AGE 84 yrs. 11 mos. 27 ds. If LESS than 1 day, hrs. or min.?

The CAUSE OF DEATH* was as follows:

8 OCCUPATION (a) Trade, profession, or particular kind of work Housewife (b) General nature of industry business, or establishment in which employed (or employer) ✓

Arterio Sclerosis

9 BIRTHPLACE (City or town, State or foreign country) Ray Co Missouri

(Duration) 2 yrs. mos. ds.

10 NAME OF FATHER James M Schooler

CONTRIBUTORY Sept 6, 1922 (Secondary) (Duration) yrs. mos. ds.

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Tennessee

(Signed) J. W. Gaines M. D. Sept 6, 1922 (Address) Rayville Mo

12 MAIDEN NAME OF MOTHER Emily Pate

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Tennessee

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Price Gorham (Address) Polo Mo.

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

15 Filed Sept. 5, 1922 Mrs. G. W. Gaines Registrar

19 PLACE OF BURIAL OR REMOVAL Sandals Cem. Ray Co. DATE OF BURIAL Sept 6, 1922

20 UNDERTAKER Alopaugh & Cowley ADDRESS Polo 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

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.

1 PLACE OF DEATH

County
 Township
 or Village
 or City
 Registration District No.
 Primary Registration District No.
 Registered No.
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)
 St. Ward)
 City
 (NO)
 File No. *191-1000*

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX
 4 COLOR OR RACE
 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
 6 DATE OF BIRTH (Month) (Day) 191... (Year)

7 AGE yrs. mos. ds.
 If LESS than 1 day.....hrs. or.....min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work.....
 (b) General nature of industry business or establishment in which employed (or employer).....

9 BIRTHPLACE (City or town, State or foreign country).....

10 NAME OF FATHER.....

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

12 MAIDEN NAME OF MOTHER.....

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant).....

15 (Address).....
 Registered

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month) 191... (Year)

17 I HEREBY CERTIFY, that I attended deceased from 191... to 191... that I last saw him..... alive on..... 191... and that death occurred, on the date stated above, at..... The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary) yrs. mos. ds.
 (Signed) 191... (Address)..... M. D.
 (Duration) yrs. mos. ds.
 (Duration) yrs. mos. ds.

*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 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.....

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 191.....

20 UNDERTAKER ADDRESS