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 3404

PLACE OF DEATH

County: wash

Township or Village or City: Harmony

Registration District No. 968

File No.

Primary Registration District No. 6184

Registered No. 1

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

FULL NAME: Mary Francis wright

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
SEX: Female	DATE OF DEATH: Jan 8 (Month) (Day), 1924 (Year)
COLOR OR RACE: w	
SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Maried	
DATE OF BIRTH: Jan (Month) (Day), 1875 (Year)	I HEREBY CERTIFY, that I attended deceased from Jan 7, 1924, to Jan 8, 1924, that I last saw her alive on Jan 7, 1924, and that death occurred, on the date stated above, at ____ m.
AGE: 48 yrs. 11 mos. 19 ds. If LESS than 1 day, ___ hrs. or ___ min.?	The CAUSE OF DEATH* was as follows: Carcinoma of cervix uteri
OCCUPATION (a) Trade, profession, or particular kind of work: House wife	48 46
(b) General nature of industry, business, or establishment in which employed (or employer): —	(Duration) ___ yrs. 6 mos. 0 ds.
BIRTHPLACE (City or town, State or foreign country): wash CO	Contributory (SECONDARY) —
PARENTS — NAME OF FATHER: Stephen SKaggs	(Duration) — yrs. — mos. ds.
BIRTHPLACE OF FATHER (City or town, State or foreign country): Ky	(Signed) Joseph L Thurman M. D.
MAIDEN NAME OF MOTHER: nurvey Hutt	Jan 25, 1924 (Address) Potosi Mo
BIRTHPLACE OF MOTHER (City or town, State or foreign country): old Country	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Roy wright (ADDRESS) Palmer mo.	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: Shole Creek Oxford Co. DATE OF BURIAL: Jan 10, 1924
Filed Jan 25, 1924 T W Gillam REGISTRAR	UNDERTAKER: James Larmer ADDRESS: run Lr.ght

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 _____

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

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.