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

PLACE OF DEATH

County Oregon

Township Woodside or Village Greer or City ____ (No. ____ St.: ____ Ward)

Registration District No. 636 — File No. 47764-a

Primary Registration District No. 5843 — Registered No. ____

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

FULL NAME Nancy Ellen Harrod

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH: May (Month) 28 (Day), 1821 (Year)

AGE: 97 yrs. 6 mos. 3 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Home Wife none
(b) General nature of industry, business, or establishment in which employed (or employer): ____

BIRTHPLACE (City or town, State or foreign country): Washington Ind

PARENTS
NAME OF FATHER: Joseph Allison
BIRTHPLACE OF FATHER (City or town, State or foreign country): South Carolina
MAIDEN NAME OF MOTHER: Mary Ragsdale
BIRTHPLACE OF MOTHER (City or town, State or foreign country): S. C.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. E. Harrod
(ADDRESS) Greer Mo

Filed Jan 20, 1917. Enoch Bailey REGISTRAR

2. MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: December (Month) 1st (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 20, 1916, to Dec 1st, 1916, that I last saw her alive on Dec 1st, 1916, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Old age
11A
16.2 10 (Duration) ____ yrs. ____ mos. 11 ds.

Contributory (Secondary) ____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) B. O. Hennigan M. D.
Jan 11, 1917 (Address) Greer 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: Hickory Grove — DATE OF BURIAL: Dec 2 1916
UNDERTAKER: J. F. Bentley — ADDRESS: Greer 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.
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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 o hospital or give its N of street an

MISSOURI STATE BOARD OF H
BUREAU OF VITAL STATISTIC
CERTIFICATE OF DEATH

Revised United States Standard

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... (Month) ..... (Day), 1..... (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

..... (Month) ..... (Day)

I HEREBY CERTIFY, that I attended deced

....., 191....., to.....

that I last saw h..... alive on.....

and that death occurred, on the date stated above, at.....

The CAUSE OF DEATH* was as follows:

.....

.....

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

Contributory.....
(SECONDARY)

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

(Signed).....

....., 191.... (Address).....

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.

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

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURI
UNDERTAKER	ADDRESS

"Typhoid pneumonia"; *Lobar pneumonia; Broncho-pneumonia*; "Pneumonia," unqualified, is indefinite.