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

1 PLACE OF DEATH

County Schuyler

Township Prairie Registration District No. 806 File No. 10944

or

Village Primary Registration District No. 6057 Registered No.

or

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

2 FULL NAME Augusta Yearns

PERSONAL AND STATISTICAL PARTICULARS		
3 SEX: Female	4 COLOR OR RACE: white	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed
6 DATE OF BIRTH: Oct 27, 1839 (Month) (Day) (Year)		
7 AGE: 80 yrs. 3 mos. 24 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): Germany		
PARENTS: 10 NAME OF FATHER: Dont Know		
11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Dont Know		
12 MAIDEN NAME OF MOTHER: Dont Known		
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Dont Know		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) J. H. Yearns (Address) Queen City		
15 Filed Feb 23, 1920 W H Gieber, Registrar		

MEDICAL CERTIFICATE OF DEATH	
16 DATE OF DEATH: Feb 21, 1920 (Month) (Day) (Year)	
17 I HEREBY CERTIFY, that I attended deceased from July 1, 1919, to Feb 21, 1920, that I last saw her alive on Feb 15, 1920, and that death occurred, on the date stated above, at 11:30 P m.	
The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage and debility from age	
(Duration) 1 yrs. 8 mos. ds.	
CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.	
(Signed) W H Gieber, M. D. Feb 23, 1920 (Address) Queen City Mo	
*State the Disease Causing Death, or, in deaths 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: Germania Cem	DATE OF BURIAL: Feb 23, 1920
20 UNDERTAKER: D Riley	ADDRESS: Downing Mo

LOCAL REGISTRAR'S RECORD — DO NOT TEAR LEAF OUT

1 PLACE OF DEATH

County .....

Township ..... or

Village ..... or

City ..... (NO. ....., ... St.; ..... Ward)

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

Registration District No. .....

Primary Registration District No. .....

File No. .....

Registered No. .....

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

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), 1..... (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)

PARENTS

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) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day), 191..... (Year)

17 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.

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

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.