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 Wayne

Township Cedarcreek

or

Village ~~Brunot~~

or

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

Registration District No. 893 File No. 8395

Primary Registration District No. 6195 Registered No. 2

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

FULL NAME Hellen Allnata Thomas.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White American

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): single

DATE OF BIRTH: Aug. 19th (Month) (Day), 1909. (Year)

AGE: _____ yrs. 6 mos. 22 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): Brunot, Mo.

PARENTS

NAME OF FATHER: A. J. Thomas

BIRTHPLACE OF FATHER (City or town, State or foreign country): Brunot

MAIDEN NAME OF MOTHER: Lucy Lovelace

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Wayne Co.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C S F Jones

(ADDRESS) Brunot Mo.

Filed Mar 11, 1910. O A Myers REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: March 10th (Month) (Day), 1910 (Year)

I HEREBY CERTIFY, that I attended deceased from March 8, 1910, to March 10, 1910, that I last saw her alive on March 10, 1910, and that death occurred, on the date stated above, at 12 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar 108

was sick 2 weeks.

(Duration) _____ yrs. _____ mos. 14 ds.

Contributory (SECONDARY) _____

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

(Signed) C S F Jones M. D.

3-11, 1910 (Address) Brunot Mo.

X *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. 6 mos. 22 ds. In the State _____ yrs. 6 mos. 28 ds.

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

Former or usual residence Usual residence

PLACE OF BURIAL OR REMOVAL: Brunot

DATE OF BURIAL: March 12, 1910

~~UNDERTAKER~~ Sexton: J. R. Midkiff

ADDRESS: Brunot

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases especially i

Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "*Asthenia*," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ..... , ... St.; ..... Ward .....

MISSOURI STATE BO
BUREAU OF VITAL
CERTIFICATE OF

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

DATE OF DEATH

..... (Month)

I HEREBY CERTIFY, that I

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

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

and that death occurred, on the date st

The CAUSE OF DEATH* was as follow

.....

.....

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

Contributory
(SECONDARY)
..... (Duration) ..... yrs.

(Signed) .....

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

*State the Disease Causing Death, or, in deat
(1) Means of Injury; and (2) whether Accidental, Sui

LENGTH OF RESIDENCE (FOR HOSPITALS, I
RECENT RESIDENTS)

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

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

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL

UNDERTAKER