WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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 Marion

Township ~~Fabius~~ or Village or City Palmyra (NO. ____ St.; ____ Ward)

Registration District No. 548 File No. 31256

Primary Registration District No. 4325 Registered No. 8

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

FULL NAME Not named

PERSONAL AND STATISTICAL PARTICULARS

SEX Male

COLOR OR RACE Negro

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

DATE OF BIRTH Oct 17 (Month) (Day) 1910 (Year)

AGE ____ yrs. ____ mos. ____ ds.

If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .1

BIRTHPLACE (City or town, State or foreign country) Palmyra Mo

PARENTS

NAME OF FATHER Steven Dogan

BIRTHPLACE OF FATHER (City or town, State or foreign country) South Carolina

MAIDEN NAME OF MOTHER Ida Baptist

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Fankel KL

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ida Dogan

(ADDRESS) Palmyra

Filed Oct. 18, 1910, S. Sanford REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Palmyra, Oct. 17, 1910 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 17, 1910, to Oct 17, 1910, that I last saw him alive on Oct 17, 1910, and that death occurred, on the date stated above, at 8 10 P m.

The CAUSE OF DEATH* was as follows:

Still Borne

NO COD

(Duration) X yrs. X mos. X ds.

Contributory (SECONDARY) ✓

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

(Signed) B. Y. Jaudon M. D.

(Address) Palmyra 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 Palmyra

DATE OF BURIAL Oct. 18, 1910

UNDERTAKER Quest Bros

ADDRESS Palmyra, Mo

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 .....

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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