

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 Saline  
Township Miami or Village \_\_\_\_\_  
City Miami (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_  
Registration District No. 7974477 File No. 32824  
Primary Registration District No. 6030 Registered No. \_\_\_\_\_

FULL NAME (unnamed) Phornator (If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Female</u>	COLOR OR RACE <u>Black</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	DATE OF DEATH <u>Sept</u> <u>30</u> , 19 <u>10</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>Sept</u> , <u>30</u> , 19 <u>00</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>X</u> , 19 <u>10</u> , to <u>X</u> , 19 <u>10</u> , that I last saw her alive on <u>X</u> , 19 <u>10</u> , and that death occurred, on the date stated above, at <u>3 A.</u> m. The CAUSE OF DEATH* was as follows:	
AGE <u>Still born</u> yrs. _____ mos. _____ ds.		IF LESS than 1 day, _____ hrs. or _____ min.?	<u>Still born (Premature)</u> <u>Cause unknown</u> <u>X</u> (Duration) <u>X</u> yrs. _____ mos. _____ ds.	
OCCUPATION (a) Trade, profession, or particular kind of work <u>X</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>X</u>			Contributory (SECONDARY) <u>X</u> (Duration) _____ yrs. _____ mos. _____ ds.	
BIRTHPLACE (City or town, State or foreign country) <u>Miami</u>			(Signed) <u>H. D. Grady</u> M. D. <u>Oct 1</u> , 19 <u>10</u> (Address) <u>Miami Mo</u>	
PARENTS	NAME OF FATHER <u>Al Phornator</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Saline Co Mo</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)	
	MAIDEN NAME OF MOTHER <u>Anna Phornator</u>		At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Miami Mo</u>		Where was disease contracted if not at place of death? Former or usual residence _____	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>H. D. Grady</u> (ADDRESS) <u>Miami Mo</u>			PLACE OF BURIAL OR REMOVAL <u>Miami Mo</u> DATE OF BURIAL <u>Sept 30</u> , 19 <u>10</u>	
Filed <u>Oct 1</u> , 19 <u>10</u> <u>Frank H. Sullivan</u> REGISTRAR			UNDERTAKER <u>Friends</u> ADDRESS <u>Miami Mo</u>	

