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

PLACE OF DEATH

County Pulaski

Township Roubidoux

or

Village

or

City (NO. , St.; Ward)

Registration District No. 715

Primary Registration District No. 5944

File No. 15384

Registered No.

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

FULL NAME Nettie Pruett

PERSONAL AND STATISTICAL PARTICULARS

SEX: female

COLOR OR RACE: white

~~SINGLE~~ MARRIED ~~WIDOWED~~ ~~OR DIVORCED~~ (~~Write the word~~): Married

DATE OF BIRTH: 4 (Month) 12 (Day), 1878 (Year)

AGE: 33 yrs. 11 mos. — ds.

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

OCCUPATION
(a) Trade, profession, or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE (City or town, State or foreign country): Pulaski Co Mo

PARENTS

NAME OF FATHER: Geo. Myers

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

MAIDEN NAME OF MOTHER: M. Frances Barnes

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Texas Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Heck

(ADDRESS) Cookville

Filed Apr. 9, 191__. R. C. Howlett REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Mar (Month) 28 (Day), 1911 (Year)

I HEREBY CERTIFY, that I attended deceased from Mar. 10, 191__, to Mar. 28, 1911, that I last saw her alive on Mar. 10, 1911, and that death occurred, on the date stated above, at ___ m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

23A

(Duration) 3 yrs. ___ mos. ___ ds.

Contributory (SECONDARY)

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Dr. Hillie M. D.

9, 191__ (Address) Plato 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: Macedonia

DATE OF BURIAL: 4-30, 1911

UNDERTAKER: L. Fisher

ADDRESS: Bloodland

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 _____

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