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 Dunklin

Township Cotton Hill

or

Village 2

or

City Townley Mo (NO. , St.: Ward)

Registration District No. 289

Primary Registration District No. 5407

File No. 34254

Registered No. 96

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

FULL NAME Abbie Florida

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH: Jan 21 (Month) 1910 (Day) 2 (Year)

AGE: 1 yrs. 9 mos. 2 ds.

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

OCCUPATION
(a) Trade, profession, or particular kind of work: 0
(b) General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE (City or town, State or foreign country): Townley Mo.

PARENTS

NAME OF FATHER: John Florida

BIRTHPLACE OF FATHER (City or town, State or foreign country): Wilson Co. Tenn.

MAIDEN NAME OF MOTHER: Gertie Lane

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Mont Vernin Ills.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. E. White

(ADDRESS) Townley Mo.

Filed 10/12 1911. S. E. Mitchell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

DATE OF DEATH: Oct. (Month) 11 (Day), 1911 (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 6th, 1911, to Oct 11th, 1911, that I last saw her alive on Oct 11th, 1911, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

9

1011 9

(Duration) yrs. 1 mos. 7 ds.

Contributory (SECONDARY) Broncho Pneumonia

(Duration) yrs. mos. 5 ds.

(Signed) S E Mitchell M. D.

10-12 1911 (Address) Malden 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: Stephens Cemetry

DATE OF BURIAL: Oct. 12 1911

UNDERTAKER: W. L. Craig

ADDRESS: Malden 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 _____

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

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.