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: Ozark

Township: Jackson

or Village:

or City: (NO. St.: Ward)

Registration District No. 646 File No. 14448

Primary Registration District No. 5655 Registered No.

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

FULL NAME Della R Welch

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Married

DATE OF BIRTH: Oct. (Month) 7 (Day), 1885 (Year)

AGE: 23 yrs. 6 mos. 11 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): Q-O

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

PARENTS
NAME OF FATHER: John R. Vaughn
BIRTHPLACE OF FATHER (City or town, State or foreign country): N. C.
MAIDEN NAME OF MOTHER: Ritter
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) P J Vaughn

(ADDRESS) Almarthy

Filed Apr 28 1912 G. H. Taylor REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Apr (Month) 18 (Day), 1912 (Year)

I HEREBY CERTIFY, that I attended deceased from Apr. 17, 1912, to Apr. 18, 1912, that I last saw her alive on Apr. 18, 1912, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Puerperal Fever

(Duration) yrs. mos. ds.

137

Contributory (SECONDARY) Child Birth

(Duration) yrs. mos. ds.

(Signed) G. H. Taylor (M. D.

Apr. 28 1912 (Address) Almartha 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: Sowders Cemetery

DATE OF BURIAL: Apr. 18 1912

UNDERTAKER: B. C. Harris

ADDRESS: Almartha

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

PLACE OF DEATH

County.....

Township .....
or
Village.....
or
City .....(NO.....,.....St.:.....Ward)

Registration District No..... File No.....

Primary Registration District No..... Registered No.....

[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

.....(Month) .....(Day), 1.....(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

.....(Month) .....(Day), 191.....(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