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

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

PLACE OF DEATH

County: Pemiscot

Township or Village or City: Steele (NO. ____ St.: ____ Ward)

Registration District No. 655 — File No. 17837

Primary Registration District No. 4392 — Registered No. 13.

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

FULL NAME Myrtle Jeters

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: Oct (Month) 16th (Day), 1902 (Year)

AGE: 9 yrs. 6 mos. 20 ds. — If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work: School Girl

(b) General nature of industry, business, or establishment in which employed (or employer): —

BIRTHPLACE (City or town, State or foreign country): Tennessee

PARENTS

NAME OF FATHER: Thomas Jeters

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

MAIDEN NAME OF MOTHER: Addie Wheat

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Tennessee

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Addie Manning, (Mother)

(ADDRESS) Steele, Mo

Filed May 6th, 1912. H. Doerner, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: May (Month) 6th (Day), 1912 (Year)

I HEREBY CERTIFY, that I attended deceased from January 2d, 1912, to May 5th, 1912, that I last saw her alive on May 5th, 1912, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

23 A

(Duration) ___ yrs. 11 mos. 16 ds.

Contributory (SECONDARY): None

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

(Signed) W. A. Sessions M. D.

May 6th, 1912 (Address) Steele, 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: Summer

DATE OF BURIAL: May 6 1912

UNDERTAKER: C. P. Howard

ADDRESS: Steele Mo

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

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PLACE OF DEATH

County _____

Township _____ *or*

Village _____ *or*

City _____ (NO. _____ _____ St.; _____ Ward)

MISSOURI STATE BOARD OF HEAL

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurr hospital or inst give its NAME of street and num

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 _____, _____ (Month) (Day)

I HEREBY CERTIFY, that I attended deceased _____, 191____, to _____, 1

that I last saw h____ alive on _____, 19

and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) ____ yrs. ____ mos. ____

Contributory _____
(SECONDARY)

_____ (Duration) ____ yrs. ____ mos. ____

(Signed) _____

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 19
UNDERTAKER	ADDRESS