

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.

PLACE OF DEATH		BUREAU OF VITAL STATISTICS	
COUNTY		CERTIFICATE OF DEATH	
County <u>North</u>	Registration District No. <u>903</u>	File No. <u>25304</u>	
Township <u>Fletcher</u>	Primary Registration District No. <u>62/2</u>	Registered No. <u>11</u>	
Village _____	City _____ (NO. _____ St. _____ Ward _____)	[If death occurred in a hospital or institution, give its NAME instead of street and number]	
FULL NAME <u>Harriett Ellen White</u>			
PERSONAL AND STATISTICAL PARTICULARS		MEDICAL CERTIFICATE OF DEATH	
SEX <u>Female</u>	COLOR OR RACE <u>White</u>	DATE OF DEATH <u>July 2</u> , 191 <u>2</u>	
DATE OF BIRTH <u>June 24</u> , 185 <u>8</u>		I HEREBY CERTIFY, that I attended deceased from <u>Jan 1</u> , 191 <u>1</u> , to <u>July 2</u> , 191 <u>2</u>	
AGE <u>54</u> yrs. <u>18</u> mos. <u>18</u> ds.		that I last saw him alive on <u>July 2</u> , 191 <u>2</u>	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u>		and that death occurred, on the date stated above, at <u>4:20</u> m.	
(b) General nature of industry, business, or establishment in which employed (or employer) <u>u u</u>		The CAUSE OF DEATH* was as follows:	
BIRTHPLACE (City or town, State or foreign country) <u>Henry Co Ky</u>		<u>Septicemia</u> 48	
PARENTS		<u>Paralysis of heart</u> 49B	
		<u>Asphyxia</u> 36	
		(Duration) <u>1</u> yrs. <u>1</u> mos. <u>1</u> ds.	
		Contributory <u>Cerebral arteriosclerosis</u>	
NAME OF FATHER <u>Wm D Davis</u>		(Signed) <u>John Andrews</u> M. D.	
BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Brown Co Ohio</u>		<u>July 2</u> , 191 <u>2</u> (Address) <u>Shatt City</u>	
MAIDEN NAME OF MOTHER <u>Elizabeth Jenkins</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 MOTHER (City or town, State or foreign country) <u>Logan Co Ky</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE		At place of death _____ yrs. _____ mos. _____ ds. In the _____ yrs. _____ mos. _____ ds.	
(Informant) <u>Wm White</u>		Where was disease contracted if not at place of death? _____	
(ADDRESS) <u>Drama Mo</u>		Former or usual residence _____	
Filed <u>July 2</u> , 191 <u>2</u> <u>John Andrews</u>		PLACE OF BURIAL OR REMOVAL <u>Shatt Cemetery</u>	
REGISTRAR		DATE OF BURIAL <u>July 4</u> , 191 <u>2</u>	
		ADDRESS <u>Grand City Mo</u>	

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

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

County Registration District No. File No.
 Township Primary Registration District No. Registered No.
 or
 Village
 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 (If file the word)

DATE OF BIRTH (Month) (Day) (Year)

AGE yrs. mos. ds. If LESS than 1 day, hrs. 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)

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 , 19 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from , 19 , to , 19 , that I last saw h alive on , 19 , and that death occurred, on the date stated above, at in. The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) , 19 (Address) M. D.

*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. State yrs. mos. ds. In the

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