

Ans

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

PLACE OF DEATH

County _____

Township _____
or _____Village _____
or _____

City _____ (NO. _____)

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

(If death occurred
in hospital or
give its No.
of street and
ward)

St. _____ Ward _____

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____ COLOR OR RACE _____
SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year) _____
If less than
1 day, _____ hrs.
or _____ min.?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)NAME OF
FATHERBIRTHPLACE
OF FATHER
(City or town, State or foreign country)MAIDEN NAME
OF MOTHERBIRTHPLACE
OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed _____, 191____

REGISTRAR

FROM
STATE BOARD OF HEALTH

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____

I HEREBY CERTIFY, that I attended deceased

that I last saw him _____, 191____, to _____
alive on _____

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

The CAUSE OF DEATH* was as follows: _____

(Duration) _____ yrs. _____ mos.

(Duration) _____ yrs. _____ mos.

(Signed) _____

(Address) _____

*State the Disease Causing Death, or, in deaths from Violent
(1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TR
RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. 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

UNDERTAKER

ADDRESS