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 Jasper

Township Mineral or Village ____ or City ____

Registration District No. 405

Primary Registration District No. ~~[illegible]~~ 5339

File No. 5620

Registered No. 5

(NO. ____ St.: ____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Jabez Petefish

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH: Oct 10 (Month), (Day), 1832 (Year)

AGE: 80 yrs. 3 mos. 3 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): 1-0 [illegible]

BIRTHPLACE (City or town, State or foreign country): Pike Co. Illinois

PARENTS
NAME OF FATHER: George Petefish
BIRTHPLACE OF FATHER (City or town, State or foreign country): Unknown
MAIDEN NAME OF MOTHER: Unknown
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs M. M. Petefish
(ADDRESS) Oronogo, Mo

Filed Feb 8th 1913 Frank Shiffern REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Jan 13 (Month), (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 27, 1912, to Jan 13, 1913, that I last saw him alive on Jan 13, 1913, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Influenza

IIB

(Duration) ____ yrs. ____ mos. 17 ds.

Contributory (SECONDARY) ____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) B M Heyne M. D.

Feb 8 1913 (Address) Alba

*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: Park Cemetery, Mo. DATE OF BURIAL: Jan 16 1913

UNDERTAKER: Snell Und Co. ADDRESS: Carthage, Mo.

PLACE OF DEATH

County.....

Township ..... or Village ..... or City .....

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

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

(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**

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.

WRITE PLAINLY, WITH UNFADING INK—LEAVE NO ERASURES OR ALTERATIONS ANYWHERE ON RECORD