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: Dent

Township: Newman

or Village:

or City: (NO. St.; Ward)

Registration District No. 269 File No. 25986

Primary Registration District No. 5376 Registered No. 5

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

FULL NAME Unnamed

PERSONAL AND STATISTICAL PARTICULARS

SEX: Boy

COLOR OR RACE: white

SINGLE / MARRIED / WIDOWED / OR DIVORCED (Write the word)

DATE OF BIRTH: July (Month) 9th (Day), 1913 (Year)

AGE: 6 hrs. (yrs. mos. 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): D-O

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

PARENTS
NAME OF FATHER: Jesse L. Dennison
BIRTHPLACE OF FATHER (City or town, State or foreign country): Waba Falls Okla.
MAIDEN NAME OF MOTHER: Clauna Hammon
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Rolla Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jesse L. Dennison
(ADDRESS) Hobson Mo.

Filed aug 9, 1913 Wilson M. Lenox REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: July (Month) 15 (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from July 9, 1913, to July 15, 1913, that I last saw him alive on July 15, 1913, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth
Congenital Debilitation
1st
1st (Duration) yrs. mos. 6 ds.

Contributory (SECONDARY) not known (Duration) yrs. mos. ds.

(Signed) Wilson M. Lenox M. D.
Aug 20, 1913 (Address) Hobson 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: Cary Cemetery
DATE OF BURIAL: July 16, 1913
UNDERTAKER: Archie Sellers
ADDRESS: Hobson Mo.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

MISSOURI STATE E
BUREAU OF VIT
CERTIFICATE

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____
or
Village _____ Primary Registration District No. _____ Registere
or
City _____ (NO. _____, _____ St.; _____ V

FULL NAME _____

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

DATE OF DEATH

_____ (Month)

I HEREBY CERTIFY, that _____, 191__, to _____ that I last saw h_____ alive on _____ and that death occurred, on the date The CAUSE OF DEATH* was as foll

_____

_____

_____ (Duration) _____

Contributory _____
(SECONDARY)
_____ (Duration) _____ y

(Signed) _____

_____, 191__ (Address) _____

*State the Disease Causing Death, or, in deat (1) Means of Injury; and (2) whether Accidental, Suic

LENGTH OF RESIDENCE (FOR HOSPITALS, IN RECENT RESIDENTS)

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

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

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL

UNDERTAKER