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: Cape Gir

Township: ~~Hubble~~

or Village: White Water

or City: ____ (NO. ____ St.: ____ Ward)

Registration District No. 130 File No. 32301

Primary Registration District No. 4073, Registered No. 6

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

FULL NAME Alva Willa

PERSONAL AND STATISTICAL PARTICULARS

SEX: Woman

COLOR OR RACE: W.

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

DATE OF BIRTH: Aug. (Month) 23 (Day) 1885 (Year)

AGE: 28 yrs. 2 mos. ____ ds.

If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): 9—0

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

PARENTS

NAME OF FATHER: Hollard H. Dieden

BIRTHPLACE OF FATHER (City or town, State or foreign country): Cape Co.

MAIDEN NAME OF MOTHER: D. K.

BIRTHPLACE OF MOTHER (City or town, State or foreign country): D. K.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alva Willa

(ADDRESS) Whitewater Mo

Filed Oct 24, 1913. A. M. Murphy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct. (Month) 23 (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from Oct. 9, 1913 to Oct. 23, 1913, that I last saw her alive on Oct. 23, 1913, and that death occurred, on the date stated above at 2 a.m.

The CAUSE OF DEATH* was as follows:

Peritonitis

1450

129

36 (Duration) ____ yrs. ____ mos. 12 ds.

Contributory (SECONDARY) Puerpal sepsis

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

(Signed) A. M. Murphy M. D.

Oct. 24, 1913 (Address) Whitewater

*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: [illegible]

DATE OF BURIAL: Oct. 24 1913

UNDERTAKER: J. M. Slagle

ADDRESS: Whitewater, Mo.

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

PLACE OF DEATH

County _____

Township _____ *or* Village _____ *or* City _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[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.