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 Gasconade

Township Boulware

or Village

or City (NO. , St.; Ward)

Registration District No. 307 File No. 32617

Primary Registration District No. 5425 Registered No.

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

FULL NAME Pearl Redden

**PERSONAL AND STATISTICAL PARTICULARS**

SEX: Femil

COLOR OR RACE: white

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

DATE OF BIRTH: Dec. (Month) 14 (Day) 1911 (Year)

AGE: 1 yrs. 9 mos. ds.

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

OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

BIRTHPLACE (City or town, State or foreign country): Mt Sterling Mo

PARENTS

NAME OF FATHER: Alford Redden

BIRTHPLACE OF FATHER (City or town, State or foreign country): Bl. Mo U.S.A.

MAIDEN NAME OF MOTHER: Elsbeth Krider

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Mo U.S.A.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John S Euler

(ADDRESS) Bay Mo

Filed Oct 3, 1913. John S Euler REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH: Oct. (Month) 2 (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 1, 1913, to Oct 2, 1913, that I last saw her alive on Oct 2, 1913, and that death occurred, on the date stated above, at 9 A.m.

The CAUSE OF DEATH* was as follows:

Diptheria

10

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) John S Euler M. D.

Oct 3, 1913 (Address) Bay 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: New Bethel

DATE OF BURIAL: Oct 3, 1913

UNDERTAKER: Jno H Gidinghagen

ADDRESS: Mt Sterling Mo

**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 _____

Township _____ Registration District No. _____ File No. _____

*or*

Village _____ Primary Registration District No. _____ Registered No. _____

*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 (*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 OF DEATH**

DATE OF DEATH

_____ (Month) _____ (Day), 191____ (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 |