MARGIN RESERVED FOR BINDING

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 Johnson

Township or Village or City Warrensburg (NO. 323 McGoodwin St.; 4 Ward)

Registration District No. 431 File No. 1547

Primary Registration District No. 3023 Registered No. 5

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

FULL NAME Hugh Fisher White

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

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

DATE OF BIRTH: Sept (Month) 10 (Day) 1913 (Year)

AGE: yrs. 4 mos. 8 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):

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

PARENTS
NAME OF FATHER: E. F. White
BIRTHPLACE OF FATHER (City or town, State or foreign country): Johnson Co. Mo.
MAIDEN NAME OF MOTHER: Lottie Fisher
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Warrensburg Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. F. White

(ADDRESS) Warrensburg Mo

Filed Jan. 21, 1914 D. Cadwick REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Jan (Month) 18 (Day) 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan. 24, 1914, to Jan. 18, 1914, that I last saw him alive on Jan. 17, 1914, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Result of Whooping Cough Pumps and Thrush

(Duration) yrs. 1 mos. 8 ds.

Contributory (SECONDARY) Chicken Pox

(Duration) yrs. mos. 6 ds.

(Signed) O. B. Hall M. D.

Jan. 18, 1914 (Address) Warrensburg 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: City Cemetery

DATE OF BURIAL: Jan 18 1914

UNDERTAKER: C. G. Danner

ADDRESS: Warrensburg Mo

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

1 PLACE OF DEATH

.....

.....p..... 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.]

ULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

BIRTH

..... 1 .....
(Month) (Day) (Year)

.....yrs.....mos.....ds. | If LESS than 1 day.....hrs. or.....min.?

TION
e, profession, or
r kind of work.....
ral nature of industry
or establishment in
ployed (or employer) .....

ACE
n,
gn country)

AME OF
ATHER

IRTHPLACE
F FATHER
City or town, State or foreign country)

less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or ter-

*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 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.....

R

cupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... 191.....
(Month) (Day) (Year)

17 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)

..... 191.....

.....Address).....

ONE IS TRUE TO THE BEST OF MY KNOWLEDGE

.....ant).....

IRTHPLACE
F MOTHER
City or town, State or foreign country)

AIDEN NAME
F MOTHER

19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL

..... 191.....

20 UNDERTAKER | ADDRESS