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 Pettis

Township or Village or City Sedalia (NO. ______ St.; ______ Ward)

Registration District No. 668 — File No. 1997

Primary Registration District No. 3032 — Registered No. 11

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

FULL NAME Thelma Elizebeth Young

PERSONAL AND STATISTICAL PARTICULARS	
SEX: Girl	COLOR OR RACE: White
SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single	
DATE OF BIRTH: Nov (Month) 3 (Day), 1908 (Year)	
AGE: 5 yrs. 2 mos. 10 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): Pleasant Hill Mo	
PARENTS — NAME OF FATHER: Fred D Young	
BIRTHPLACE OF FATHER (City or town, State or foreign country): Blue Springs Mo	
MAIDEN NAME OF MOTHER: Eva Glen McDaniel	
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Holden Mo	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred D Young

(ADDRESS) Sedalia Mo 1530 Harkness

Filed Jan 14 1914 W. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH January 13 (Month) (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Jany 8, 1914, to Jany 13, 1914, that I last saw her alive on Jany 13, 1914, and that death occurred, on the date stated above, at 9 a.m. The CAUSE OF DEATH* was as follows:

120 B Acute Ileo Colitis

(Duration) ___ yrs. ___ mos. 9 ds.

Contributory (SECONDARY) ______ (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) A E Monroe M. D.

1-13, 1914 (Address) Sedalia 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	DATE OF BURIAL
Holden Mo	Jan 15 1914
UNDERTAKER	ADDRESS
McLaughlin Bros	Sedalia Mo

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

_____, 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.