

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.

PLACE OF DEATH

County Pettis
 Township _____
 or
 Village _____
 or
 City Sedalia (NO. 315 Marion St.; _____ Ward)

MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 668 File No. 2008
 Primary Registration District No. 2032 Registered No. 24

FULL NAME Lloyd Bick of Weather

(If death occurred in a hospital or institution, give NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>single</u>
DATE OF BIRTH <u>1</u> <u>March</u> <u>26</u> , 19 <u>12</u> (Month) (Day) (Year)		
AGE <u>1</u> yrs. <u>9</u> mos. <u>26</u> ds.		If LESS than 1 day, ____ hrs. or ____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>has none</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		

BIRTHPLACE
(City or town, State or foreign country) Highville Mo

PARENTS	NAME OF FATHER <u>John Darius Weather</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Lamotte Mo</u>
	MAIDEN NAME OF MOTHER <u>Della Spratley</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Benton Co,</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) 315 Marion
Erva Spratley
 (ADDRESS)
Jan 31 1914 H. B. P.
 Filed _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
1 Jan 21, 1914
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from
1/11, 1914, to 1/21, 1914,
 that I last saw him alive on 1/21, 1914,
 and that death occurred, on the date stated above, at 4 p. m.
 The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia
107H

(Duration) ____ yrs. ____ mos. 10 ds.
 Contributory (SECONDARY)
 (Duration) ____ yrs. ____ mos. ____ ds.
 (Signed) [Signature] M. D.
 (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 <u>Dresden Mo</u>	DATE OF BURIAL <u>Jan 23</u> , 19 <u>14</u>
UNDERTAKER <u>McLaughlin</u>	ADDRESS <u>Sedalia</u>

PLACE OF DEATH

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

Revised United States Standard Certificate

County _____

Township _____ or Village _____ or City _____

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

(NO. _____ St. _____ Ward _____)

(If death occurs in hospital or funeral home, give its NAME and street and number)

FULL NAME

Elizabeth McHenry Allen

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (If not the word)
DATE OF BIRTH	(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) _____

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 _____, 19____, _____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____

I HEREBY CERTIFY, that I attended deceased _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____
The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

(Signed) _____ (Duration) _____ yrs. _____ mos.

(Address) _____, 19____

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos.

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

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 19____

UNDERTAKER _____ ADDRESS _____