N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIA
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION i

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

Bandy

PLACE OF DEATH

County Pettis

Township

or

Village

or

City Sedalia (NO. 405-E-17" St.; 3d Ward)

Registration District No. 668 File No. 2014

Primary Registration District No. 3032 Registered No. 29

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

FULL NAME Ruth Beecham

PERSONAL AND STATISTICAL PARTICULARS

SEX: female

COLOR OR RACE: white

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

DATE OF BIRTH: Mar. 20" (Month) — (Day), 1912 (Year)

AGE: 1 yrs. 10 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): none

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

PARENTS

NAME OF FATHER: T. J. Beecham

BIRTHPLACE OF FATHER (City or town, State or foreign country): Maryland

MAIDEN NAME OF MOTHER: Vera Barrett

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Arkansas

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) T. J. Beecham

(ADDRESS) Sedalia Mo.

Filed Jan 28, 1914. Fr. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Jan (Month) 29 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 18, 1914, to Jan 22, 1914, that I last saw her alive on Jan 22, 1914, and that death occurred, on the date stated above, at 8:20 P.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

108

(Duration) ___ yrs. ___ mos. 19 ds.

Contributory (SECONDARY)

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

(Signed) W. L. Bandy M. D.

Jan 25, 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: Sedalia Mo

DATE OF BURIAL: Jan. 29, 1914

UNDERTAKER: M Laughlin

ADDRESS: Sedalia Mo

MISSOURI STATE BOARD OF HEALT
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

NS should state
a very important.

tem of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state
DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.