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 Davies

Township Jamesport
or
Village
or
City (NO. , St.; Ward)

Registration District No. 252 File No. 4385

Primary Registration District No. 5351 Registered No. 4

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

FULL NAME Loraine Wilson Mundell

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female
COLOR OR RACE: white
SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: Feb. (Month) 20 (Day), 1914 (Year)

AGE: 0 yrs. 0 mos. 3 ds. If LESS than 1 day, 4 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): Davies Co. Mo.

PARENTS
NAME OF FATHER: M. A. Mundell
BIRTHPLACE OF FATHER (City or town, State or foreign country): Kansas
MAIDEN NAME OF MOTHER: Lizzie Wilson
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Illinois

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. A. Mundell

(ADDRESS) Jamesport Mo.

Filed Feb 24, 1914 C. G. McKinley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Feb 23 (Month) (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 20, 1914, to Feb 23, 1914, that I last saw her alive on Feb 22, 1914, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Morbus Caeruleus
157C

150

(Duration) yrs. mos. 3 ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) McKinley & Harris M. D.

Feb 24 1914 (Address) Jamesport 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: 100F Jamesport Mo

DATE OF BURIAL: , 191

UNDERTAKER: W. R. Kingdon

ADDRESS: Jamesport Mo.

PLACE OF DEATH

County

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

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

Registration District No. File No.

Primary Registration District No. Registered No.

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

FULL NAME Lorraine Wilson Mundell

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.

PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH Feb 20, 1911
(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) Lewis Co.

PARENTS

NAME OF FATHER M. A. Mundell

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

MAIDEN NAME OF MOTHER Lorraine Wilson

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

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