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: Washington — Registration District No. 429 — File No. 5192

or Village: ~~Knobnoster~~ — Primary Registration District No. 5584 — Registered No. 3

or City: ..... (NO. ..... St.: ..... Ward)

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

FULL NAME Paul Allen Macrae

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, ~~MARRIED~~, ~~WIDOWED~~, OR DIVORCED (Write the word)
boy	white	Single

DATE OF BIRTH: Nov (Month) 13 (Day), 1913 (Year)

AGE: ..... yrs. 2 mos. 24 ds. — If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): .....

BIRTHPLACE (City or town, State or foreign country): Independence

PARENTS

NAME OF FATHER: W. S. Macrae

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

MAIDEN NAME OF MOTHER: Eddie English

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. S. Macrae

(ADDRESS) Knobnoster Mo

Filed Feb 5, 1914. Henry Park, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Feb (Month) 6 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 29, 1914, to Feb 6, 1914, that I last saw him alive on Feb 6, 1914, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows: Congenital Pneumonia

(Duration) ..... yrs. ..... mos. 10 ds.

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

(Signed) D. C. Shy M. D.

Feb 6, 1914 (Address) Knobnoster 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
Knob Noster Mo	Feb 7, 1914
UNDERTAKER	**ADDRESS**
C. L. Sault	Knob Noster

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE 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

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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