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

5631

PLACE OF DEATH

County Pemiscot

Township Holland

or

Village

or

City (NO. St.; Ward)

Registration District No. 1127

Primary Registration District No. 6281

File No. 4

Registered No. 4

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

FULL NAME John Edward Edington

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: June (Month) 18 (Day), 1912 (Year)

AGE: 1 yrs. 8 (19) mos. ds.

If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE (City or town, State or foreign country): Pemiscot Co., Mo

PARENTS

NAME OF FATHER: William Edington

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

MAIDEN NAME OF MOTHER: Flora Liley

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS) Holland Mo

Filed Feb 21 1914 Edington

J E Redman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Feb (Month) 17 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 12, 1914, to Feb 17, 1914, that I last saw him alive on Feb 15, 1914, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Measles

Mic

(Duration) yrs. mos. 15 ds.

Contributory (SECONDARY) Brokhitis

(Duration) yrs. mos. 5 ds.

(Signed) J. H. Phipps M. D.

2-22, 1914 (Address) Holland 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: No 8 Cemetery

DATE OF BURIAL: 2/19" 1914

UNDERTAKER: None

ADDRESS: None

Revised United States Standard Certificate

MISSOURI STATE BOARD OF HEA
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 occ hospital or i give its NAM of street and n

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____ (Month) _____ (Day), 1 _____ (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 _____ (Month) _____ (Day)

I HEREBY CERTIFY, that I attended deceas _____, 191__, to _____ that I last saw h _____ alive on _____ and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____

Contributory _____
(SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____

(Signed) _____

_____, 191__ (Address) _____

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANS RECENT RESIDENTS)

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

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

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURI
UNDERTAKER	ADDRESS