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 Bollinger.

Township Lorance

or

Village

or

City (NO. St.; Ward)

Registration District No. 64 File No. 7409

Primary Registration District No. 5108 B Registered No. 6

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

FULL NAME Kate Pitman.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: white

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

DATE OF BIRTH: Dont Know (Month) (Day), 1869 (Year)

AGE: 45 yrs. mos. ds.

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

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

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

PARENTS

NAME OF FATHER: Andy Clippard

BIRTHPLACE OF FATHER (City or town, State or foreign country): Sarah S Clippard

MAIDEN NAME OF MOTHER:

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. J. Grimsley

(ADDRESS) Laplin Mo

Filed 3-10, 1914 J J Chandler REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Mar (Month) 7 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 23, 1914, to Mar 7, 1914 that I last saw her alive on Feb. 28, 1914 and that death occurred, on the date stated above, at 8 30 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

92

(Duration) yrs. mos. 8 ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) J. M. Finney. M. D.

Mar 7, 1914 (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: Laplin Cemetary

DATE OF BURIAL: Mar 2, 1914

UNDERTAKER

ADDRESS: Lutesville Mo

PLACE OF DEATH

MISSOURI STATE BOARD OF HEAL
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 occur hospital or in give its NAME of street and nu

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

....., ...
(Month) (Day)

I HEREBY CERTIFY, that I attended decease

....., 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 Cause (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIE 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 BURIAL
	.....
UNDERTAKER	ADDRESS