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

11937

PLACE OF DEATH

County Chariton

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

Registration District No. 171 File No. _____

Primary Registration District No. 4100 Registered No. 14

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

FULL NAME Temple (Premature

PERSONAL AND STATISTICAL PARTICULARS

SEX Female

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

DATE OF BIRTH April (Month) 6 (Day), 1914 (Year)

AGE _____ yrs. _____ mos. _____ ds.

If LESS than 1 day, 2 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) Keytesville Mo

PARENTS

NAME OF FATHER Richard Temple

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

MAIDEN NAME OF MOTHER Mattie Brockman

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Shopshire

(ADDRESS) Keytesville, Mo.

Filed April 6, 1914. L. H. Wallace REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April (Month) 6 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from April 6, 1914, to April 6, 1914, that I last saw her alive on April 6, 1914, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Premature Birth

159

151

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. W. Shopshire M. D.

April 6, 1914 (Address) Keytesville, 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 Asbury Chapel

DATE OF BURIAL April 6, 1914

UNDERTAKER The Family

ADDRESS Keytesville Mo

PLACE OF DEATH

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

County _____

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

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 _____

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**

same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report