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 Macon

Township Jackson
or
Village
or
City ~~Anabel Mo~~ (NO. —, St.: Ward)

Registration District No. 970 File No. 16653

Primary Registration District No. 5702 Registered No.

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

FULL NAME Clifford Clara Perry

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

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

DATE OF BIRTH: May (Month) 12th (Day), 1914 (Year)

AGE: 0 yrs. 0 mos. 5 ds. If LESS than 1 day, ___ 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):

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

PARENTS
NAME OF FATHER: C. O. Perry
BIRTHPLACE OF FATHER (City or town, State or foreign country): Ill
MAIDEN NAME OF MOTHER: Daisy Belle Perry
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ill

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): C D McAffee

(ADDRESS) Atlanta Mo

Filed May 20, 1914. H. P. Hall REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: May (Month) 16 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from May 12, 1914, to May 14, 1914, that I last saw him alive on May 14, 1914, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Umbilical Hemorage

161 D

157

(Duration) ___ yrs. ___ mos. ___ ds.

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

(Signed) H. P. Hall M. D.

May 18, 1914 (Address) Nickelstown

*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: Mt Salem

DATE OF BURIAL: May 17, 1914

UNDERTAKER: H M Grodding

ADDRESS: Atlanta Mo

MISSOURI STATE BOARD OF HEALTH
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 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

.....(Month) .....(Day), *I*.....(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), *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

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.