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.

Dr mental

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

PLACE OF DEATH

County Pettis

Township or Village or City Sedalia NO. ..... St.; ..... Ward)

Registration District No. 668 File No. 20175

Primary Registration District No. 3032 Registered No. 143

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

FULL NAME Louise B Salisbury

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

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

DATE OF BIRTH: June 15 (Month) (Day), 1914 (Year)

AGE: ..... yrs. ..... mos. 3 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): Sedalia

PARENTS

NAME OF FATHER: Arthur Salisbury

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

MAIDEN NAME OF MOTHER: Fay Siler

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Salisbury

(ADDRESS)

Filed June 20 1914 F. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: June (Month) 19 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from June 15, 1914, to June 18, 1914, that I last saw her alive on June 18, 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. 4 ds.

Contributory (SECONDARY) None

8 (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. [illegible] M. D.

June 19, 1914 (Address) Sedalia 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: Crown Hill

DATE OF BURIAL: June 19, 1914

UNDERTAKER: McLaughlin Bros

ADDRESS: 515 Ohio St

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

....., *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

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 import