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: Lawrence

Township: Freistatt

or Village:

or City: (NO. , St.; Ward)

Registration District No. 473 File No. 10 23173

Primary Registration District No. 5637 Registered No. 10

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

FULL NAME Norman Doss

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

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

DATE OF BIRTH: May (Month) 31 (Day), 1914 (Year)

AGE: yrs. 1 mos. 29 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): Lawrence Co. Mo.

PARENTS

NAME OF FATHER: Chas. Doss

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

MAIDEN NAME OF MOTHER: Eva Vonault

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) David Obermann

(ADDRESS) R 3 Monett Mo

Filed 7-29, 1914. H E Maier REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: July (Month) 29 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from July 26, 1914, to July 29, 1914, that I last saw him alive on July 29, 1914, and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Diarrhea and Enteritis

(Duration) yrs. mos. ds.

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

(Signed) Carlos Copeland M. D.

July 29, 1914 (Address) Freistatt 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: Freistatt Mo

DATE OF BURIAL: 7-30, 1914

UNDERTAKER: John Bobb

ADDRESS: Freistatt Mo

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

PLACE 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 _____ (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), 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.