

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

PLACE OF DEATH

County Cass
Township Park
or
Village Strasburg
or
City Strasburg Mo.

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

Registration District No. 15-9 File No. 25558
Primary Registration District No. 5-224 Registered No. 9
St. _____ Ward _____

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

FULL NAME Hecil Alexander

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED Single WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH July 7, 1909
(Month) (Day) (Year)
AGE 6 yrs. 1 mos. 15 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) Kans

PARENTS
NAME OF FATHER Lewis L Alexander
BIRTHPLACE OF FATHER Mo
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Foy Paul
BIRTHPLACE OF MOTHER Mo
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lewis Alexander

(ADDRESS) Pleasant Hill Mo

Filed 8-30 1914 W Beckman

REGISTRAR

1 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 22, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 8-22, 1914, to 8-22, 1914, that I last saw her alive on 8-22, 1914,

and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal Toxemia
12013

(Duration) ____ yrs. ____ mos. 12 hrs

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

Signed W Beckman M. D.
8-22 1914 (Address) Strasburg, 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 Bluff Springs DATE OF BURIAL 8-23 1914
UNDERTAKER Parker ADDRESS Pleasant Hill Mo

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

PLACE OF DEATH

County _____

Township _____
or _____

Village _____
or _____

City _____ (NO. _____)

Registration District No. _____

Primary Registration District No. _____

File No. _____

Registered No. _____

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

St. _____ Ward _____

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	DATE OF BIRTH	
			(Month) _____ (Day) _____ (Year) _____	

AGE _____ (Month) _____ (Day) _____ (Year) _____

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) _____

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) _____ (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.

(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. 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 _____