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.

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

PLACE OF DEATH

County Knox

Township Sheltonsi Registration District No. 1029 File No. 8 26533

or

Village Primary Registration District No. 5602 Registered No. 8

or

City (NO. St.: Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME William Gregory

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

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

DATE OF BIRTH: Dec (Month) 15 (Day), 1895 (Year)

AGE: 18 yrs. 8 mos. 4 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer): Employer

BIRTHPLACE (City or town, State or foreign country): Dallas ~~Louisa~~ Co Iowa

PARENTS
NAME OF FATHER: James Gregory
BIRTHPLACE OF FATHER (City or town, State or foreign country): Louisa Co Iowa
MAIDEN NAME OF MOTHER: Elza Schenfelt
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Iowa

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. A. Gregory

(ADDRESS) Hurdland Mo

Filed Aug 21 1914 D. L. Howerton M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from Aug 15, 1914, to Aug 19, 1914, that I last saw him alive on Aug 19, 1914, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

01

(Duration) ___ yrs. ___ mos. 20 ds.

Contributory (SECONDARY)

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

(Signed) P. Sherlock M. D.

Aug 21, 1914 (Address) Novelty, 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: Louisa Hill

DATE OF BURIAL: Aug 24 1914

UNDERTAKER: F. N. Magruder

ADDRESS: Hurdland Mo

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

PLACE OF DEATH

County .....

Township ..... or Village ..... or City .....

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

(NO. ..... St.: ..... Ward)

[If death occurred in 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 him alive on ....., 191.. and that death occurred, on the date stated above, at .....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. .....

Contributory ..... (SECONDARY)

..... (Duration) ..... yrs. ..... mos. .....

(Signed) ..... M.

....., 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, RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. .....

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