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: Mercer

Township: Marion

or Village:

or City: (No.: St.: Ward:)

Registration District No.: 553

Primary Registration District No.: 5746

File No.: 29778

Registered No.:

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

FULL NAME Infant Son of Jesse & Sarah Draper

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

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

DATE OF BIRTH: Sept 5, 1914 (Month, Day, 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): Mercer Co. Mo

PARENTS

NAME OF FATHER: Jesse Draper

BIRTHPLACE OF FATHER (City or town, State or foreign country): Putnam Co. Mo

MAIDEN NAME OF MOTHER: Sarah Crews

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Mercer Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Etta Crews

(ADDRESS) Mercer Mo

Filed 9/10, 1914 J. E. Fern REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Sept 8, 1914 (Month, Day, Year)

I HEREBY CERTIFY, that I attended deceased from Sept 5, 1914, to Sept 8, 1914, that I last saw h~~e~~ alive on Sept 7, 1914, and that death occurred, on the date stated above, at 4a m.

The CAUSE OF DEATH* was as follows:

Immature born 2 mo before term

159 (Duration) yrs. mos. ds.

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

X (Signed) J. E. Hammer M. D.

Sept 8, 1914 (Address) Mercer

*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: Early Cemetery

DATE OF BURIAL: Sept 8, 1914

UNDERTAKER: Jesse Draper

ADDRESS: Mercer Mo

MISSOURI STATE BOARD OF H
BUREAU OF VITAL STATISTI
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 hospital give its] of street a

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

I HEREBY CERTIFY, that I attended dece

....., 191...., to .....

that I last saw h..... alive on .....

and that death occurred, on the date stated above, at.

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

GE should be stated EXACTLY. PHYSICIANS should state assified. Exact statement of OCCUPATION is very important.