

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

PLACE OF DEATH
County Schuyler
Township Liberty
or
Village
or
City

Registration District No. 806 File No. 37552
Primary Registration District No. 6060 Registered No. 19
St. Ward

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

FULL NAME Not Named. Twin No 2

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)
DATE OF BIRTH Nov 14 1914
(Month) (Day) (Year)
AGE _____ If LESS than 1 day, _____ hrs. or _____ min.?
_____ yrs. _____ mos. 2 ds.
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) Schuyler Co Mo

PARENTS
NAME OF FATHER Wm. Ayr.
BIRTHPLACE OF FATHER (City or town, State or foreign country) Schuyler Co. Mo.
MAIDEN NAME OF MOTHER Alice Duncan.
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Adair County Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Ayr.
(ADDRESS) Laurelaster Mo.

Filed Nov 26 1914. W. F. Justice
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov 16 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,
that I last saw him alive on Nov 14, 1914,
and that death occurred, on the date stated above, at 6³⁰ A. M.
The CAUSE OF DEATH* was as follows:

Premature Birth at 8 mo
159
151
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) E. L. Mitchell M. D.
Nov 16 1914 (Address) Laurelaster 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 Webster Cemetery DATE OF BURIAL Nov 17 1914
UNDERTAKER Roberts & Heery ADDRESS Laurelaster Mo

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 _____

Township _____

or

Village _____

or

City _____ (NO _____)

Registration District _____

Primary Registration District _____

File No. _____

Registered 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 (If wife the word)
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DATE OF BIRTH	(Month) _____ (Day) _____ (Year) _____
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AGE	_____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?
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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) _____
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NAME OF FATHER	_____
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BIRTHPLACE OF FATHER	(City or town, State or foreign country) _____
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MAIDEN NAME OF MOTHER	_____
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BIRTHPLACE OF MOTHER	(City or town, State or foreign country) _____
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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)
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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 _____ in. 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. 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

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.