

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

FULL NAME

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

Registration District No.

File No.

Primary Registration District No.

Registered No.

St. Ward)

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

PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(If file the word)

DATE OF BIRTH

AGE

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

1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

I HEREBY CERTIFY, that I attended deceased from

that I last saw him alive on

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

The CAUSE OF DEATH* was as follows:

Contributory

(Signed)

*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

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

PLACE OF DEATH

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

County _____

Township _____ or _____ File No. _____

Village _____ or _____ Primary Registration District No. _____ Registered No. _____

City _____ (NO. _____) St. _____ Ward _____

(If death occurred
in hospital or institution,
give its NAME in full,
and street and number.)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____ COLOR OR RACE _____

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(If file the word)

DATE OF BIRTH

(Month) _____ (Day) _____ (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) _____

NAME OF
FATHERBIRTHPLACE
OF FATHER

(City or town, State or foreign country) _____

MAIDEN NAME
OF MOTHERBIRTHPLACE
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) _____, 191_____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased

_____ 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

(Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, (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. 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

UNDERTAKER

ADDRESS

191_____