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 Pemiscot

Township Holland, Mo.

or

Village

or

City (NO. St.; Ward)

Registration District No. 11 27

Primary Registration District No. 6281

File No. 2 1995

Registered No. 2

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

FULL NAME Milom B. Etters

**PERSONAL AND STATISTICAL PARTICULARS**

SEX: Female

COLOR OR RACE: White

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

DATE OF BIRTH: 9 (Month) 19 (Day), 1914 (Year)

AGE: yrs. 3 mos. 23 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): Holland, Mo.

PARENTS

NAME OF FATHER: O. W. Etters,

BIRTHPLACE OF FATHER (City or town, State or foreign country): Dyersburg, Tenn.

MAIDEN NAME OF MOTHER: Minia May Shaver,

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Frankfort Ky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) O. W. Etters

(ADDRESS) Holland, Mo.

Filed Jany 13, 1915 S. E. Redman REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH: 1 (Month) 12 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from 12/8, 1915, to 12/11, 1914, that I last saw her alive on 12/11, 1914, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Capilary Bronchitis,

1070 89

(Duration) yrs. mos. ds.

Contributory (SECONDARY) Tuberculous Mother

(Duration) yrs. mos. ds.

(Signed) William S Robinson M. D.

1915 (Address) Holland, 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: Sanford Mo.

DATE OF BURIAL: Jany 13, 1915

UNDERTAKER: Family Burial

ADDRESS: Holland Mo

**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.....

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

or

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

or

City .....(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 (*Write* the word) |
|---|---|---|
| | | |

DATE OF BIRTH

....., 1.....
(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)

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

....., 191....
(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.

....., 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 |