

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.)

St.

Ward)

FULL NAME

Registration District No.

Primary Registration District No.

File No.

Registered No.

[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
(Write 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)

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

1915

REGISTRAR

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

9072

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

May

25, 1915

(Month)

(Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 26th, 1915, to Mar 25, 1915, that I last saw her alive on Mar 23rd, 1915, and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Diphtheria

1578

150

(Duration) yrs. mos. ds.

Contributory

(SECONDARY)

(Duration) yrs. mos. ds.

(Signed)

Don Pierce

M. D.

Mar 25, 1915

(Address) Newark 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

DATE OF BURIAL

Newark Cemetery

May 26, 1915

UNDERTAKER

ADDRESS

Geo. W. Glover

Newark Mo.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

PLACE OF DEATH

County.....

Township.....

or

Village.....

or

City.....(NO.....)

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]

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (If write the word)

DATE OF BIRTH.....

AGE.....(Month).....(Day).....(Year).....

IF LESS than 1 day,.....hrs. or.....min.?

Yrs.....mos.....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)

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 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. 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.....