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 Dallas

Township Grant

or

Village ~~Lowesburg~~ Mo

or

City _____ (NO. _____ St. _____ Ward)

Registration District No. 242 File No. 12076

Primary Registration District No. 5335 Registered No. 6

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

FULL NAME Blanche Irene Ford

PERSONAL AND STATISTICAL PARTICULARS

SEX Female

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

DATE OF BIRTH June (Month) 16 (Day), 1911 (Year)

AGE 3 yrs. 9 mos. 13 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) ~~Bert Ford~~ Mo

PARENTS

NAME OF FATHER Bert Ford

BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo

MAIDEN NAME OF MOTHER Jana Stewart

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bert Ford

(ADDRESS) Lowesburg Mo

Filed Apr 11, 1915. W E Gammon REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mch (Month) 29 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from Mch 15, 1915, to Mch 29, 1915, that I last saw her alive on Mch 29, 1915, and that death occurred, on the date stated above, at 1230 p m.

The CAUSE OF DEATH* was as follows:

Measles

7 9

10713 06

(Duration) ___ yrs. 1 mos. ___ ds.

Contributory (SECONDARY) Bronchitis Capilary

(Duration) ___ yrs. ___ mos. 10 ds.

(Signed) W E Gammon M. D.

Apr 11, 1915 (Address) Lowesburg 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 Vlow Drive

DATE OF BURIAL 3/30, 1915

UNDERTAKER D A Lindsey

ADDRESS Lowesburg Mo

PLACE OF DEATH

County _____

Township _____
or
Village _____
or
City _____ (NO. _____, _____ St.; _____ Ward)

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

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[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

_____ (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), *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. 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

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.