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 Franklin

Township Prairie or Village or City (NO. , St.: Ward)

Registration District No. 301 File No. 12229

Primary Registration District No. 5418 Registered No. 7

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

FULL NAME Cora Etta Nappier

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE ~~MARRIED~~ ~~WIDOWED~~ ~~OR DIVORCED~~ (~~Write the word~~) Single

DATE OF BIRTH: Dec. (Month) 1 (Day), 1908 (Year)

AGE: 6 yrs. 4 mos. 5 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) Near Bunker Hill Mo

PARENTS
NAME OF FATHER: Charley F. Nappier
BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo
MAIDEN NAME OF MOTHER: Emma Schallenberg Mo
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mt. Hope Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Tom Nappier

(ADDRESS) St Clair Mo

Filed 4-6, 1915 F J Hemker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: April (Month) 6 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from March 10, 1915, to April 6, 1915, that I last saw her alive on April 6, 1915, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

108 (Duration) 92 mos. 20 ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) S. L. Dewhirst M. D.

April 6, 1915 (Address) St Clair 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: Bunker Hill

DATE OF BURIAL: April 7, 1915

UNDERTAKER: Family St Clair Mo

ADDRESS

PLACE OF DEATH

County _____

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

Registration District No. _____ Primary Registration District No. _____

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

File 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

CAUSE OF DEATH. It may be printed on reverse side. Special attention to occupational diseases. Very important.