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 Boone

Township Rockyfork

or

Village

or

City (NO. St.; Ward)

Registration District No. 74 File No. 11 21047

Primary Registration District No. 5713 Registered No. 11

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

FULL NAME Louella Irene McKenzie

PERSONAL AND STATISTICAL PARTICULARS

SEX Female

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

DATE OF BIRTH Feb (Month) 16 (Day) 1914 (Year)

AGE 1 yrs. 6 mos. 4 ds.

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

OCCUPATION
(a) Trade, profession, or particular kind of work X

(b) General nature of industry, business, or establishment in which employed (or employer) X

BIRTHPLACE (City or town, State or foreign country) Callaway Co. Mo.

PARENTS

NAME OF FATHER Charles Benton McKenzie

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

MAIDEN NAME OF MOTHER Katie Lee Karney

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas McKenzie

(ADDRESS) Centralia Mo.

Filed July 21 1915 R R Robinson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July (Month) 20 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from July 14, 1915, to July 20, 1915, that I last saw her alive on July 20, 1915, and that death occurred, on the date stated above, at 7-8 m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

1192

104

(Duration) X yrs. X mos. 7 ds.

Contributory (SECONDARY) X

X (Duration) X yrs. X mos. X ds.

(Signed) A. H. Cox M. D.

July 24 1915 (Address) Stephens

*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 X yrs. X mos. X ds. In the State X yrs. mos. ds.

Where was disease contracted if not at place of death? X

Former or usual residence X

PLACE OF BURIAL OR REMOVAL Millersburg Mo

DATE OF BURIAL July 21 1915

UNDERTAKER M. S. Bush

ADDRESS Centralia Mo

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

PLACE OF DEATH

County.....

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

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

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

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