

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 Pettis

Township _____
or
Village _____
or
City Sedalia (NO. _____)

Registration District No. 668
Primary Registration District No. 3082

File No. 22557
Registered No. 176

FULL NAME Thomas Munn

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

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE White SINGLE Single
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH July 19, 1888
(Month) (Day) (Year)

AGE 31 yrs. — mos. — ds. IF LESS than
1 day, — hrs.
or — min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Coal Miner
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE
(City or town, State or foreign country) Pittston Pa

PARENTS
NAME OF FATHER Jos Munn
BIRTHPLACE OF FATHER England
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Sara E. Ridger
BIRTHPLACE OF MOTHER England
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. B. Miller

(ADDRESS) Pittston Pa
Filed 7/22, 1914 H. B. Reed
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 21, 1914
(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:

accidentally killed by train
20719 (Duration) 175 yrs. — mos. — ds.

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

(Signed) D. P. Dyson M. D. 6/16 1914 (Address) Sedalia

*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 Forest Mo DATE OF BURIAL July 23, 1915

UNDERTAKER H. H. Hely ADDRESS Sedalia

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 _____

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

(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 fill the word)

DATE OF BIRTH _____

(Month) _____ (Day) _____ (Year) _____

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) _____

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) _____ (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) _____ (Address) _____ M. D. _____

* 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 _____