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 Audrain

Township Cuivre or Village Farber or City ____ (No. ____ St.; ____ Ward)

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

Registration District No. 921 File No. 29705

Primary Registration District No. 4557 Registered No. ____

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

**FULL NAME** Charles D. Burby.

**PERSONAL AND STATISTICAL PARTICULARS**

| SEX | COLOR OR RACE | SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) |
|---|---|---|
| Male | White | |

DATE OF BIRTH: July 12, 1915 (Month) (Day) (Year)

AGE: ____ yrs. 2 mos. 4 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) Farber Mo.

PARENTS

NAME OF FATHER Father J. Burby.

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

MAIDEN NAME OF MOTHER Anna A. Athey

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Father J Burby.

(ADDRESS) Farber Mo

Filed Oct. 9, 1915. H. M. May. REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH Sept. 16, 1915 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept. 7, 1915, to Sept 16, 1915, that I last saw him alive on Sept. 15, 1915, and that death occurred, on the date stated above, at 1. a. m.

The CAUSE OF DEATH* was as follows:

Spinal Meningitis.

15 B.

79 A 61

(Duration) ____ yrs. ____ mos. 8 ds.

Contributory (Secondary) Erysipelas

(Duration) ____ yrs. ____ mos. 5 ds.

(Signed) W. M. May. M. D.

Oct. 9, 1915 (Address): Farber 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: Farber Mo — DATE OF BURIAL: Sep 18, 1915

UNDERTAKER: W. W. Watts. — ADDRESS: Vandalia 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 |

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.