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 Carroll

Township Miami St

or Village —

or City —

Registration District No. 136 File No. 8 5719

Primary Registration District No. 5204 Registered No. 8

(NO. ____ St.; ____ Ward)

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

FULL NAME Virgil Luther Utley

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH May (Month) 26 (Day), 1893 (Year)

AGE 22 yrs. 8 mos. 28 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country) Miami Station Mo

PARENTS
NAME OF FATHER Benj. F. Utley
BIRTHPLACE OF FATHER (City or town, State or foreign country) Little Rock Ark
MAIDEN NAME OF MOTHER Minnie Beecham
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Terre Haute Ind

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B. F. Utley

(ADDRESS) Miami Sta Mo

Filed Feby 25, 1916, J. P. Logan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb. (Month) 23 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Feb. 7, 1916, to Feb. 23, 1916, that I last saw him alive on Feb. 23, 1916, and that death occurred, on the date stated above, at 5:45 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

108

(Duration) 9 yrs. 8 mos. 16 ds.

Contributory (SECONDARY) —

(Duration) — yrs. — mos. — ds.

(Signed) F. E. Thompson M. D.

2/24, 1916 (Address) Dewitt 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 Dewitt Cem

DATE OF BURIAL Feby 25, 1916

UNDERTAKER McClelle, Bros

ADDRESS Dewitt, 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

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.