MARGIN RESERVED FOR BINDING

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.

V. S. No. 2.

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

PLACE OF DEATH

County: Carter

Township: Johnson

or Village: ~~Grandin~~

or City: _____ (NO. _____ St.: _____ Ward)

Registration District No. 145 File No. 7 5733

Primary Registration District No. 5208 Registered No. 4

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

FULL NAME: Helen Louise York

PERSONAL AND STATISTICAL PARTICULARS

SEX: F. COLOR OR RACE: W SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): S.

DATE OF BIRTH: April (Month) 2 (Day), 1915 (Year)

AGE: _____ yrs. 10 mos. _____ ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): _____

BIRTHPLACE (City or town, State or foreign country): Ill.

PARENTS
NAME OF FATHER: Fred York
BIRTHPLACE OF FATHER (City or town, State or foreign country): Ill.
MAIDEN NAME OF MOTHER: Edith Bishop
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ill.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred York

(ADDRESS) Grandin Mo

Filed Feby 2nd 1916. Alexander Johnson M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Feby (Month) 2 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 30, 1916, to Feby 2, 1916, that I last saw her alive on Jan 30, 1916, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

107B 91

(Duration) _____ yrs. _____ mos. 4 ds.

Contributory (SECONDARY) _____

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

(Signed) R H Watson M. D.

Feby 2, 1916 (Address) Grandin 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: Grandin Cemetery

DATE OF BURIAL: Feb. 3, 1916

UNDERTAKER: W E McKinney

ADDRESS: Grandin Mo

V. S. No. 2.

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

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

MARGIN RESERVED FOR BINDING

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PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (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 (*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**