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

PLACE OF DEATH

County Pettis

Township _____ or Village _____ or City Sedalia (NO. _____ St.; _____ Ward)

Registration District No. 668 File No. 7495

Primary Registration District No. 3032 Registered No. 56

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

FULL NAME Infant of Ed Van Natta

PERSONAL AND STATISTICAL PARTICULARS

SEX Female | COLOR OR RACE White | SINGLE ~~MARRIED~~ ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word)

DATE OF BIRTH Feb (Month) 8 (Day), 1916 (Year)

AGE _____ yrs. _____ mos. 10 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) Sedalia

PARENTS
NAME OF FATHER Ed Van Natta
BIRTHPLACE OF FATHER (City or town, State or foreign country) — Mo
MAIDEN NAME OF MOTHER Zelpha Ball
BIRTHPLACE OF MOTHER (City or town, State or foreign country) ~~Zelpha Ball~~ Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Cora Lorrell

(ADDRESS) Sedalia

Filed Feb 19, 1916 F. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb (Month) 18 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Feb. 8, 1916, to Feb 18, 1916, that I last saw her alive on Feb 18, 1916, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Meningitis

15 (Duration) _____ yrs. _____ mos. 10 ds.

Contributory (SECONDARY) Premature Birth

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

(Signed) K. N. Barnum M. D.

2/19, 1916 (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 Crown Hill | DATE OF BURIAL Feb 19, 1916

UNDERTAKER McKenzie | ADDRESS Sedalia

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE 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 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