N. E.—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.

...CONTAINING INK—THIS IS A PERMANENT RECORD

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

PLACE OF DEATH

County Pettis

Township Sedalia

or

Village

or

City (NO. St.; Ward)

Registration District No. 668

Primary Registration District No. ~~3239~~ 5889

File No. 15480

Registered No. 105

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

FULL NAME Isabel Ferrier

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

~~SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)~~ Single

DATE OF BIRTH: Sept 27, 1900 (Month) (Day) (Year)

AGE: 15 yrs. 4 mos. 22 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): —

BIRTHPLACE (City or town, State or foreign country): Hillsboro Texas

PARENTS

NAME OF FATHER: Walter Ferrier

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

MAIDEN NAME OF MOTHER: Victoria Wh

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Conway Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs H B Ruffian

(ADDRESS) Sedalia Mo

Filed April 10 1916 F. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: April 9th, 1916 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 22, 1916, to Apr. 9, 1916, that I last saw her alive on Apr 8, 1916, and that death occurred, on the date stated above, at 12 40 p.m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis.

(Duration) yrs. 3 mos. — ds.

Contributory (SECONDARY) none.

(Duration) yrs. mos. ds.

(Signed) E. R. Walker, M. D.

Apr 10, 1916 (Address) Sedalia 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: Sedalia Mo

DATE OF BURIAL: 4/12 1916

UNDERTAKER: McKenzie

ADDRESS: Sedalia Mo

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

PLACE OF DEATH

County.....

Township .....
or
Village.....
or
City .....

Registration District No.....

Primary Registration District No.....

File 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 (*Write* the word)

DATE OF BIRTH

....., 1.....
(Month) (Day) (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

....., 191.....
(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)..... 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A