

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

City or town, State or foreign country

Registration District No.

Primary Registration District No.

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 Female COLOR OR RACE White SINGLE Single MARRIED Single WIDOWED Single OR DIVORCED Single (Write the word)

DATE OF BIRTH

AGE

OCCUPATION
Trade, profession, or particular kind of work

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

BIRTHPLACE

City or town, State or foreign country

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)

ed 5 19 1916

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

5 - 18, 1916
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Apr 1, 1916, to May 18, 1916, that I last saw him alive on May 18, 1916, and that death occurred, on the date stated above, at 6³⁰ a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs
23 A
106 B

(Duration) yrs. 6 mos. ds.

Contributory (SECONDARY)

(Duration) 2 yrs. mos. ds.

(Signed) C. L. Parkhurst M. D.(Address) Houstonia

*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

Houstonia Mo.

DATE OF BURIAL

5-19 1916

UNDERTAKER

A. C. Wright

ADDRESS

Houstonia Mo.

PLACE OF DEATH

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

County.....

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

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

City..... (NO..... St..... Ward.....)

(If death occurred
hospital or institu-
give its NAME in
of street and number

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (If file the word)
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DATE OF BIRTH..... (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).....

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.....

I HEREBY CERTIFY, that I attended deceased....., 191....., to....., 191....., that I last saw h..... alive on....., 191..... and that death occurred, on the date stated above, at.....
The CAUSE OF DEATH* was as follows:

Contributory

(SECONDARY)

(Signed).....

(Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, RECENT RESIDENTS)

At place of death..... yrs..... mos..... ds. State..... yrs..... mos.....

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.

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MARGIN RESERVED FOR BINDING

V. B. No. 2