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.

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

21726

PLACE OF DEATH

County Johnson

Township Post Oak

or

Village

or

City (NO. St.; Ward)

Registration District No. 430 File No. 4

Primary Registration District No. 5586 Registered No. 78

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

FULL NAME Edna May Parman

PERSONAL AND STATISTICAL PARTICULARS

SEX: 7

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Infant

DATE OF BIRTH: June (Month) 13 (Day), 1916 (Year)

AGE: yrs. mos. 14 hrs. ds.

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

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

BIRTHPLACE (City or town, State or foreign country): R.D. Chilhowee Mo

PARENTS

NAME OF FATHER: Lowe Parman

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

MAIDEN NAME OF MOTHER: Anna Hidler

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lowe Parman

(ADDRESS) R.D. Chilhowee

Filed June 15, 1916. R. P. Koons REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: June (Month) 14 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from June 13, 1916, to June 14, 1916, that I last saw her alive on June 13, 1916, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Premature birth

8 months gestation

159 (Duration) yrs. mos. ds.

Contributory (SECONDARY) unknown

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

6/14 1916 (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: Providence Cemetery

DATE OF BURIAL: June 14, 1916

UNDERTAKER: Ray Sweeney

ADDRESS: Chilhowee

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

Revised United States Standard

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 hospital or institut give its NAME inst 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

..... , 19..... (Month) (Day) (Y

I HEREBY CERTIFY, that I attended deceased f ..... , 191..... , to ..... , 191 that I last saw h ..... alive on ..... , 19 and that death occurred, on the date stated above, at ..... The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration) ..... yrs. ..... mos.

Contributory .....
(SECONDARY)
..... (Duration) ..... yrs. ..... mos.

(Signed) .....

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

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

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

At place of death ..... yrs. ..... mos. ..... ds. In the 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
UNDERTAKER	ADDRESS