V. S. No. 2.

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

PLACE OF DEATH

County Saline

Township Liberty

or Village

or City (NO. St.; Ward)

Registration District No. 801 File No. 23339

Primary Registration District No. 6045 Registered No.

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

FULL NAME Lonnie Upton

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 PERMANENT RECORD

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

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

DATE OF BIRTH: 5 - 11, 1916 (Month) (Day) (Year)

AGE: ....yrs. ....mos. 3 ds. If LESS than 1 day, ...hrs. or ....min.?

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): Houstonia Mo

NAME OF FATHER: Allen Upton

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

MAIDEN NAME OF MOTHER: Ruth Yonkee

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Allen Upton

(ADDRESS)

Filed June 1, 1916. J. S. Harrison REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: 5 - 14, 1916 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 11, 1916, to May 14, 1916; that I last saw he alive on May 14, 1916, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

107A

(Duration) ....yrs. ....mos. 1 ds.

Contributory (Secondary) Unknown

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

(Signed) C. E. Parkhurst M. D.

May 15, 1916 (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 - 17, 1916

UNDERTAKER: R. C. Voss

ADDRESS: Houstonia, Mo.

V. S. No. 2.

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 HEALT

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 hospital or institu give its NAME in of street and numbe

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

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)

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 ....., 191

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) ..... M

....., 191.... (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. 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
	....., 19
UNDERTAKER	ADDRESS