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

County Pettis

Township ..... or Village ..... or City Sedalia (NO. 616 E 12th St.; ..... Ward)

Registration District No. 668 File No. 25363

Primary Registration District No. 3032 Registered No. 191

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

FULL NAME Leonia Viola Dittmer

PERSONAL AND STATISTICAL PARTICULARS

SEX F

COLOR OR RACE W

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) —

DATE OF BIRTH April (Month) 7 (Day), 1914 (Year)

AGE 2 yrs. 3 mos. 2 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 Mo

PARENTS

NAME OF FATHER Fred Dittmer

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

MAIDEN NAME OF MOTHER Mable Harper

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred Dittmer

(ADDRESS) Sedalia Mo

Filed July 10 1916. F. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July (Month) 9 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from June 25, 1916, to July 9, 1916, that I last saw her alive on July 9, 1916, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Entero-colitis

120 B 105

..... (Duration) ..... yrs. ..... mos. 20 ds.

Contributory (SECONDARY) None.

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

(Signed) S Chosmiung M. D.

July 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 Smithton Mo

DATE OF BURIAL 7-11 1916

UNDERTAKER McLaughlin

ADDRESS B W

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

County.....

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

or

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

or

City ..... (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