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 HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Howell

Township Dry Creek Registration District No. 387 File No. 6 34186-A

or Village ..... Primary Registration District No. 5540 Registered No. 6

or City ..... (NO. ..... St.; ..... Ward)

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

FULL NAME Harvey H. Twichell

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

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

DATE OF BIRTH: March (Month) 10 (Day), 1898 (Year)

AGE: 18 yrs. 7 mos. 5 ds. If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

BIRTHPLACE (City or town, State or foreign country): Kansas City

PARENTS
NAME OF FATHER: L. B. Twichell
BIRTHPLACE OF FATHER (City or town, State or foreign country): Minn
MAIDEN NAME OF MOTHER: Alice McNarie
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Kas

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. B. Twichell

(ADDRESS) Pomona Mo

Filed Oct 16, 1916 A. P. Cottrell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct 15 (Month) (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from October 8th, 1916, to October 14th, 1916, that I last saw him alive on October 14, 1916, and that death occurred, on the date stated above, at 6 A.m.

The CAUSE OF DEATH* was as follows:

Intestinal perforation with general peritonitis

(Duration) - yrs. - mos. one ds.

Contributory (SECONDARY) Typhoid Fever with Lobar Pneumonia

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

(Signed) D. D. Leon M. D.

Oct 16, 1916 (Address) Pomona 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: Kansas City, Kas

DATE OF BURIAL: Oct 18, 1916

UNDERTAKER: McFarland Undo

ADDRESS: West Plains Mo

V. S. No. 2.

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

PLACE OF DEATH

County.....

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

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

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

(NO. ....., ... St.; ..... Ward)

[If death occurred in 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 ..... (Month) ..... (Day) ....., 1..... (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 ..... (Month) ..... (Day) ....., 191..... (Year)

I HEREBY CERTIFY, that I attended deceased fro ....., 191....., to ....., 191.... that I last saw h ..... alive on ....., 191.... and that death occurred, on the date stated above, at ..... n

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, stat (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, o 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