WHITE 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.

PLACE OF DEATH

County Knox

Township Benton

or

Village

or

City (NO. St.: Ward)

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

Registration District No. 441 File No. 1894-I

Primary Registration District No. 5600 Registered No. 2

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

FULL NAME Ester May Huling

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH July (Month) 1 (Day), 1871 (Year)

AGE 45 yrs. 6 mos. 8 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) Invalid.

BIRTHPLACE (City or town, State or foreign country) Missouri

PARENTS

NAME OF FATHER Oldridge Huling

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

MAIDEN NAME OF MOTHER Lutie Hanks

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Homer Bowen

(ADDRESS) Hundland Mo

Filed Feb 10, 1917. W. J. Jurgens REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH January (Month) 9th (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 1st, 1917, to Jan 7, 1917, that I last saw her alive on Jan 7, 1917, and that death occurred, on the date stated above, at ___ m.

The CAUSE OF DEATH* was as follows:

Epilepsy

65 (Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) Grippe

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

(Signed) Taylor A Campbell M. D.

Jan 10, 1917. (Address) Edina 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 Lucus Hill.

DATE OF BURIAL Jan 11th 1917

UNDERTAKER H. Romaynder

ADDRESS Hundland

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 _____ or Village _____ or City _____ (NO. _____, _____ St., _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[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 _____ (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 _____ (Month) _____ (Day), 191__ (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