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 Putnam

Township Medicine Registration District No. 717 File No. 2614

or

Village Primary Registration District No. 5946 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 May Zephyr Scott

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

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

DATE OF BIRTH: April (Month) 22d (Day), 1882 (Year)

AGE: 34 yrs. 9 mos. 4 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country): Putnam County Mo

PARENTS

NAME OF FATHER: Wm Little

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

MAIDEN NAME OF MOTHER: Mary Dare

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Little

(ADDRESS) Lucerne Mo

Filed 1-27, 1917. F D Rice REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Jan (Month) 26 (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 25, 1917, to Jan 26, 1917, that I last saw her alive on Jan 26, 1917, and that death occurred, on the date stated above, at 50 m.

The CAUSE OF DEATH* was as follows: Shock following birth of Child Instrumental Delivery.

1440 (Duration) 136 yrs. ___ mos. ___ ds.

Contributory (SECONDARY) 16 Pound Child

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

(Signed) G. A. Steele M. D.

Jan 27, 1917 (Address) Lucerne 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: J Lee Hawk

DATE OF BURIAL: Lucerne 191

UNDERTAKER: Lucerne Cem

ADDRESS: 1-28-17

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

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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