LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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

File No. 6853

Registered No. 4

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

1 PLACE OF DEATH

County: Monroe

Township: Woodlawn or Village: ..... or City: ..... (NO. ....., ... St., ... Ward)

Registration District No. 587

Primary Registration District No. 5785

2 FULL NAME: Minnie Kate Love

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Aug. (Month) 12 (Day), 1897 (Year)

7 AGE: 19 yrs. 6 mos. 4 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry business, or establishment in which employed (or employer): .....

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

PARENTS

10 NAME OF FATHER: Joseph W. Love

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

12 MAIDEN NAME OF MOTHER: Arminda Burton

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph W. Love
(Address) Madison Mo

15 Filed Feb. 16, 1917 Fred O. Wedding, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb. (Month) 16 (Day), 1917 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Aug., 1916, to Feb. 16, 1917, that I last saw her alive on Feb. 15, 1917, and that death occurred, on the date stated above, at 6 A.m.

The CAUSE OF DEATH* was as follows:
Chronic Invalidism
200A
(Duration) 6 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Hyatt M. D.
Feb. 16, 1917 (Address) Clarence

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 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 .....

19 PLACE OF BURIAL OR REMOVAL: Love Cemetery
DATE OF BURIAL: 2/18, 1917

20 UNDERTAKER: Fred G. Thompson
ADDRESS: Madison Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association.]

MISSOURI STATE BOARD
BUREAU OF VITAL STA
CERTIFICATE OF DE

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE
MARRIED
WIDOWED
OR DIVORCED
(*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day) ..... 1..... (Year)

7 AGE

.....yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

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

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DE

16 DATE OF DEATH

..... (Month)

17 I HEREBY CERTIFY, that I atte

....., 191....., to .....

that I last saw h..... alive on .....

and that death occurred, on the date stated a

The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration) ..... yrs.

CONTRIBUTORY
(Secondary) .....

..... (Duration) ..... yrs.

(Signed) .....

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from (1) Means of Injury; and (2) whether Accidental, S

18 LENGTH OF RESIDENCE (For Hospitals, Inst or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... y

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL

DAT

20 UNDERTAKER

ADDR

"Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial*