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

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

PLACE OF DEATH

County Henry

Township Tebo

or

Village

or

City (NO. St.: Ward)

Registration District No. 349 File No. 10078

Primary Registration District No. 3487 Registered No. 50

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

FULL NAME Minnie Fields

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Dec (Month) 4 (Day), 1913 (Year)

AGE 1 yrs. 3 mos. 9 ds. If LESS than 1 day, hrs. or min.?

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

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

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

PARENTS

NAME OF FATHER Wm Fields

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

MAIDEN NAME OF MOTHER Vannie Avery

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wallace Avery

(ADDRESS) Windsor

Filed March 15 1917. A A Gray REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March (Month) 14 (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from March 6, 1917, to March 14, 1917, that I last saw her alive on March 9, 1917, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

9/107A

(Duration) yrs. mos. 10 ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) E Dare M. D.

3/14 1917 (Address) Leeton

*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 Sedalia

DATE OF BURIAL March 15 1917

UNDERTAKER W C Burke

ADDRESS Sedalia

PLACE OF DEATH

County_____

Township _____ *or*
Village _____ *or*
City _____ (NO. _____ St.: _____ Ward)

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

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: December (Month) 4th (Day), 1915 (Year)

AGE: 1 yrs. 3 mos. 9 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

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.