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.

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

PLACE OF DEATH

County Lawrence

Township ____ or Village ____ or City Pierce City (NO. ____ St.; ____ Ward)

Registration District No. 471 File No. 111133

Primary Registration District No. 14284 Registered No. 166

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

FULL NAME Infant

PERSONAL AND STATISTICAL PARTICULARS

SEX F

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Infant

DATE OF BIRTH March (Month) 16 (Day), 1917 (Year)

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

OCCUPATION
(a) Trade, profession, or particular kind of work Infant
(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 A R Daggett

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

MAIDEN NAME OF MOTHER Lure Shaw

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W W Daggett

(ADDRESS) Pierce City Mo

Filed 3-16, 1917 J. Barnhill REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March (Month) 16 (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from 3/16, 1917, to 3/16, 1917, that I last saw her alive on 3/16, 1917, and that death occurred, on the date stated above, at 1030 A m.

The CAUSE OF DEATH* was as follows:

Mother 159 had Typhoid and Measles and Child was born at 30th wk of Pregnancy. Was not a matured foetus

Contributory (SECONDARY) 151 (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) H. Ross Clark M. D.

3/16 1917 (Address) Pierce City, 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 Pierce City Mo

DATE OF BURIAL March 16, 1917

UNDERTAKER John Seufert

ADDRESS Pierce City Mo

Revised United States Standard Certificate of Death

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

"Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("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*

MISSOURI STATE BOA
BUREAU OF VITAL S
CERTIFICATE OF D

PLACE OF DEATH

County.....

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

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

DATE OF DEATH

.....
(Month)

I HEREBY CERTIFY, that I a
....., 191...., to.....
that I last saw h.....alive on.....
and that death occurred, on the date sta
The CAUSE OF DEATH* was as follows:

.....

.....

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

Contributory.....
(SECONDARY)
.....(Duration).....yrs.

(Signed).....

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

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTI RECENT RESIDENTS)

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

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

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL

UNDERTAKER