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.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County Monroe

Township Union
or
Village
or
City (NO. , St.; Ward)

Registration District No. 580 File No. 11385

Primary Registration District No. 5777 Registered No. 5

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

2 FULL NAME Charlotte F. Manuel

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) 8

6 DATE OF BIRTH July (Month) 26 (Day) 1912 (Year)

7 AGE 4 yrs. 7 mos. 28 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) Monroe Co, Mo

PARENTS

10 NAME OF FATHER Geo Manuel

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

12 MAIDEN NAME OF MOTHER Nellie J. Harlow

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Manuel

(Address) Madison Mo.

15 Filed 3/24 1917 E. C. Brooks Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1 March 24 (Month) (Day) 1917 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Feb. 14, 1917, to March 23, 1917, that I last saw her alive on March 23, 1917, and that death occurred, on the date stated above, at 10:30 P.m.

The CAUSE OF DEATH* was as follows:

Malignancy of the left kidney (?)

53A 40 (Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) S. H. J. Harrell M. D.

April 2, 1917 (Address) Holliday Mo.

*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 Mount Ave Cemetery

DATE OF BURIAL 3/25 1917

20 UNDERTAKER Fred A. Thompson

ADDRESS Madison Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF H
BUREAU OF VITAL STATISTIC
CERTIFICATE OF DEATH

Revised United States Standard Certificate of Death

1 PLACE OF DEATH

County .....

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

[If de hospital give its of stree

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

....., 1.....
(Month) (Day) (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 DEATH

16 DATE OF DEATH

.....
(Month) (Day)

17 I HEREBY CERTIFY, that I attended dec

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

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

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

CONTRIBUTORY .....
(Secondary)

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

(Signed) .....

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

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

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

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

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

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURI

20 UNDERTAKER

ADDRESS

"Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.,