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: Marion

Township: Round Grove
or
Village: ~~Helvonville~~
or
City: _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. 551 — File No. 15578

Primary Registration District No. 5744 — Registered No. 8

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

FULL NAME Harriett A. Boyer

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

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

DATE OF BIRTH: October (Month) 24 (Day), 1836 (Year)

AGE: 81 yrs. 6 mos. 10 ds.

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

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

BIRTHPLACE (City or town, State or foreign country): Maryland

PARENTS

NAME OF FATHER: Henry H. White

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

MAIDEN NAME OF MOTHER: Mary E. Whitelock

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Arthur B. Boyer

(ADDRESS): Ewing Mo

Filed May 2, 1917. J. M. Crebs, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Apr. 15, 1917 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Apr. 2, 1917, to Apr. 15, 1917, that I last saw her alive on Apr. 13, 1917, and that death occurred, on the date stated above, at 7¼ a.m.

The CAUSE OF DEATH* was as follows:

Bronchi Pneumonia

(Duration) — yrs. — mos. 14 ds.

Contributory (SECONDARY): Lagrippe

(Duration) about yrs. ~~mos.~~ 20 ds.

(Signed) H. F. Rhodes M. D.

Apr. 20, 1917 (Address) Philadelphia

*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: Asbury Cemetery

DATE OF BURIAL: April 16, 1917

UNDERTAKER: Thomas Ball

ADDRESS: Ewing Mo

Revised United States Standard Certificate of Death

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

MISSOURI STATE BOARD OF HEALT
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 occ hospital or i give its NAM of street and n

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., I.....
(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

.....
(Month) (Day)

I HEREBY CERTIFY, that I attended deceas

....., 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 Ca (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN RECENT RESIDENTS)

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

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

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURI
UNDERTAKER	ADDRESS