N. B.—Every item of information should be carefully supplied. ☐ AGE should be stated EXACTLY. PHYSICIA
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is ve

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

PLACE OF DEATH

County Andaway

Township Independence

or

Village P O Parnell Mo

or

City _____ (NO. _____ St.: _____ Ward)

Registration District No. 6.26

Primary Registration District No. 5828

File No. 15722

Registered No. 24

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

FULL NAME Frank Grimit

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE ~~MARRIED~~ ~~WIDOWED~~ ~~OR DIVORCED~~ (~~Write the word~~) Single

DATE OF BIRTH: Oct. 21 (Month) (Day), 1887 (Year)

AGE: 29 yrs. 6 mos. 7 ds.

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

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer 23A
(b) General nature of industry, business, or establishment in which employed (or employer): — 106A

BIRTHPLACE (City or town, State or foreign country): Andaway Co Mo 194B

PARENTS

NAME OF FATHER: Floyd Grimit

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

MAIDEN NAME OF MOTHER: Manda Wilson

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Parnell Mo.

(ADDRESS) C A Grimit Bro

Filed Apr 28, 1917 Hiram Day REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: April (Month) 28 (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from April 14, 1917, to April 14, 1917, that I last saw him alive on April 14, 1917, and that death occurred, on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) Cold & Exposure

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) L C Wyse M. D.

April 29, 1917 (Address) Parnell

*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: Dunkard Cemetry

DATE OF BURIAL: May 3, 1917

UNDERTAKER: Roof & La Favor

ADDRESS: Parnell Mo

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 _____ (Month) _____ (Day) *1*_____ (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), *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

Accuracy 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.