MARGIN RESERVED FOR BINDING

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 Callaway.

Township Nine Mile or Village or City (NO. St.: Ward)

Registration District No. 1147 File No. 17958

Primary Registration District No. 5164 Registered No.

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

FULL NAME Willis Blaxton McCracken.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: Sept (Month) 8 (Day), 1865 (Year)

AGE: 51 yrs. 8 mos. 11 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer & Stockman
(b) General nature of industry, business, or establishment in which employed (or employer): Same

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

PARENTS
NAME OF FATHER: William McCracken
BIRTHPLACE OF FATHER (City or town, State or foreign country): Ohio
MAIDEN NAME OF MOTHER: Jane Blaxton
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wilbur McCracken

(ADDRESS) Williamsburg Mo

Filed _____, 191 J. W. Owen. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: May (Month) 19 (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from March 12, 1917, to May 19, 1917, that I last saw him alive on May 19, 1917, and that death occurred, on the date stated above, at 10.45 A.M.

The CAUSE OF DEATH* was as follows:

Gangrene of the lung, a sequel to abscess and lobar pneumonia

(Duration) ___ yrs. 2 mos. 7 ds.

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

(Signed) A. J. Courshon M. D.

May 20, 1917 (Address) Williamsburg

*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: Old Auxvasse Cem

DATE OF BURIAL: May 21 1917

UNDERTAKER: Edd Herndon.

ADDRESS: Fulton 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"

PLACE OF DEATH

County.....

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

MISSOURI STATE BOARD OF
BUREAU OF VITAL STATIST
CERTIFICATE OF DEATH

Registration District No..... File No.....

Primary Registration District No..... Registered No.....

[If de hospital give it of stree

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

.....(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) (I

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

.....

.....

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

Contributory.....
(SECONDARY)

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

(Signed).....

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

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, T 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.....

PLACE OF BURIAL OR REMOVAL	DATE OF B
UNDERTAKER	ADDRESS