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: Pecos Mashed

Township: Anderson

or Village:

or City: Gideon (NO. ..... St.: ..... Ward)

Registration District No. 55

Primary Registration District No. ~~55~~ 4033

File No. 19381

Registered No. 2

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

FULL NAME Rice Bell Brooks

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

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

DATE OF BIRTH: April 19 (Month) (Day), 1890 (Year)

AGE: 27 yrs. 1 mos. 8 ds. If LESS than 1 day, ... hrs. or ..... min.?

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

BIRTHPLACE (City or town, State or foreign country): Boonville Ind

PARENTS

NAME OF FATHER: W. T. Reed

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

MAIDEN NAME OF MOTHER: Mary Jones

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Carlie Brooks

(ADDRESS): Gideon Mo

Filed 5/28, 191.. W. V. Munna REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: May 27 (Month) (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from April 24, 1917, to May 27, 1917, that I last saw her alive on May 27, 1917, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Chronic Malaria Producing a Prophistical Condition

(Duration): 04 yrs. ..... mos. ..... ds.

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

(Signed) Thos N Cottrill M. D.

5/28, 191.. (Address) Gideon

*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: Mansfield

DATE OF BURIAL: 5/28, 1917

UNDERTAKER: Jas. Cuop

ADDRESS: Gideon

Revised United States Standard Certificate of Death

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

"Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("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 BOARD O
BUREAU OF VITAL STATI
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

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

[
ho
gi
of

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)

I HEREBY CERTIFY, that I attende

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

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

and that death occurred, on the date stated ab

The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

Contributory
(SECONDARY) .....

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

(Signed).....

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

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

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTION RECENT RESIDENTS)

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

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

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL | DATE

UNDERTAKER | ADDRE