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 Montgomery

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

Registration District No. 938

Primary Registration District No. 5786

File No. 22770

Registered No.

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

FULL NAME Charles Bakes

PERSONAL AND STATISTICAL PARTICULARS			2 MEDICAL CERTIFICATE OF DEATH
SEX: M	COLOR OR RACE: W	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married	DATE OF DEATH June (Month) 18 (Day), 1917 (Year)
DATE OF BIRTH Unknown (Month) (Day), 1917 (Year)			I HEREBY CERTIFY, that I attended deceased from 3-18, 1917, to 6-18, 1917, that I last saw him alive on 6-18, 1917, and that death occurred, on the date stated above, at 10 P.m.
AGE About 73 yrs. mos. ds.		If LESS than 1 day, hrs. or min.?	The CAUSE OF DEATH* was as follows: Dropsy 59 / 50 (Duration) yrs. mos. ds.
OCCUPATION (a) Trade, profession, or particular kind of work: Farmer			Contributory (SECONDARY) Diabetes (Duration) yrs. mos. ds.
(b) General nature of industry, business, or establishment in which employed (or employer): Don't Know			(Signed) W. W. Daniels M. D.
BIRTHPLACE (City or town, State or foreign country)			8, 191 (Address)
PARENTS: NAME OF FATHER			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
BIRTHPLACE OF FATHER (City or town, State or foreign country)			LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
MAIDEN NAME OF MOTHER			At place of death yrs. mos. ds. In the State yrs. mos. ds.
BIRTHPLACE OF MOTHER (City or town, State or foreign country)			Where was disease contracted if not at place of death?
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Arthur Graham			Former or usual residence
(ADDRESS) New Florence			PLACE OF BURIAL OR REMOVAL: Gregory Cem — DATE OF BURIAL: 6-19-1917
Filed 6-19 1917 J. E. Gibson REGISTRAR			UNDERTAKER: C. W. Hopkins — ADDRESS: Montgomery Mo

PLACE OF DEATH Joe Everett Gipson,

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

County.....

Township.....
or
Village.....
or
City.....

Registration District No.....

Primary Registration District No.....

File No.....

Registered No.....

(No.....St.;.....Ward)

[If death
hospital
give its
of street

FULL NAME.....

(Approved by U. S. Census and American Public Health

Revised United States Standard Certificate of Death

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

....., 1.....
(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) (Da

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, a

The CAUSE OF DEATH* was as follows:

OF HEAL
Statistics

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, 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 OF
UNDERTAKER	ADDRESS

"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"