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.

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

PLACE OF DEATH

County Gentry

Township Howard

or

Village

or

City (NO. St.; Ward)

Registration District No. 309 File No. 24929

Primary Registration District No. 5434 Registered No. 48

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX Male

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) single

DATE OF BIRTH July (Month) 16 (Day), 1917 (Year)

AGE yrs. mos. 1 ds.

If LESS than 1 day, 3 hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work None 157C

(b) General nature of industry, business, or establishment in which employed (or employer) None 159

BIRTHPLACE (City or town, State or foreign country) Gentry Co Mo

PARENTS

NAME OF FATHER Ben McCord

BIRTHPLACE OF FATHER (City or town, State or foreign country) Gentry Co

MAIDEN NAME OF MOTHER Goldie Sowards

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Gentry Co

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. P. Brown

(ADDRESS) Denver

Filed July 20, 1917. W. T. Martin REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July (Month) 16 (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from July 16, 1917, to July 16, 1917, that I last saw h— alive on July 16, 1917, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

150

Premature Birth.
Failure of Foramen ovale to close (Duration) yrs. mos. ds.

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

(Signed) Lewis H. Long M. D.

July 17, 1917 (Address) Denver Mo

*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 Grooms

DATE OF BURIAL 7-17, 1917

UNDERTAKER Brown Bros

ADDRESS Denver

Revised United States Standard Certificate of Death

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

MISSOURI STATE BOARD (
BUREAU OF VITAL STAT
CERTIFICATE OF DEAT

PLACE OF DEATH

County .....

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

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

..... (Month) ....., *1* ..... (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 DEAT

DATE OF DEATH

..... (Month)

I HEREBY CERTIFY, that I attend

....., 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 Ho

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIO 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	ADDRI