

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.

PLACE OF DEATH

County

Township

or

Village

or

City

Registration District No.

Primary Registration District No.

File No.

Registered No.

St.; Ward)

(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

OR DIVORCED

(If write the word)

DATE OF BIRTH

AGE

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

REGISTRAR

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

DATE OF DEATH

I HEREBY CERTIFY, that I attended deceased from

July 25, 1917, to July 26, 1917,
that I last saw him alive on July 25, 1917,
and that death occurred, on the date stated above, at 4:00 a.m.

The CAUSE OF DEATH* was as follows:

Breast cancer 2 lines
12 1/2 3 11 3
(Duration) yrs. 6 mos. — ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

*(Signed) Ed. M. M. M. D.

July 26, 1917 (Address) Sedalia, 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

DATE OF BURIAL

Lamonte

July 27, 1917

UNDERTAKER

ADDRESS

B. F. Parker

Lamonte

E. S. Triplett Deputy

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

PLACE OF DEATH

County _____
Township _____
or _____
Village _____
or _____
City _____ (NO _____)
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
(If/its the word)

DATE OF BIRTH _____ (Month) _____, 191____ (Day) _____ (Year) _____
AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min. ?

OCCUPATION _____
(a) Trade, profession, or business, or establishment in which employed (or employer)
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE _____
(City or town, State or foreign country)

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) _____, 191____ (Day) _____ (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:

Contributory _____ (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds. _____ (Signed) _____ (Address) _____, 191____ M. D.

*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. 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 _____