

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 DEATHPLACE OF DEATH
nty. Pettis
shp. Houstonia
age. _____Registration District No. 665 File No. 6 29444
Primary Registration District No. 5885 Registered No. 665

(NO. _____ St. _____ Ward _____)

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

FULL NAME

Raymond Aldredge

PERSONAL AND STATISTICAL PARTICULARS

K Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single
TE OF BIRTH 9 - 6 - 1913
(Month) (Day) (Year)
E 3 yrs. 11 mos. 13 ds. If LESS than 1 day, ____ hrs. or ____ min.?OCCUPATION
Trade, profession, or particular kind of work _____
General nature of industry, business, or establishment in which employed (or employer) _____PLACE OF BIRTH
(City or town, State or foreign country)Hughesville Mo.

NAME OF FATHER

Berry AldredgeBIRTHPLACE OF FATHER
(City or town, State or foreign country)Postal Mo.

MAIDEN NAME OF MOTHER

Daisy WithersBIRTHPLACE OF MOTHER
(City or town, State or foreign country)Lookout Mo.

ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Signant) P. B. Aldredge
(ADDRESS) Houstonia Mo.Aug 31 1917
A. Smith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 30, 1917
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Aug 25, 1917, to Aug 30, 1917, that I last saw h alive on Aug 25, 1917, and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis120 P.105Duration) ____ yrs. ____ mos. 15 ds.
Contributory (SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.(Signed) C. L. Parkhurst M. D. (Address) Houstonia

*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

Mission Church

DATE OF BURIAL

Aug 31 1917

UNDERTAKER

W. C. Voigt

ADDRESS

Houstonia Mo.

PLACE OF DEATH

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

County _____
Township _____ or _____
Village _____
City _____ (NO. _____) St.: _____ Ward) _____
Registration District No. _____ File No. _____
Primary Registration District No. _____ Registered No. _____

(If death occurred
hospital or institution
give its NAME and
of street and number)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____ COLOR OR RACE _____ SINGLE
MARRIED
WIDOWED
OR DIVORCED
(If fits 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

_____, 191____, _____ (Month) _____, _____ (Day) _____, _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased
_____, 191____, to _____, 19____,
that I last saw him alive on _____, 19____,
and that death occurred, on the date stated above, at
The CAUSE OF DEATH* was as follows:

(Duration) _____ yrs. _____ mos.

Contributory
(SECONDARY)

(Duration) _____ yrs. _____ mos.

(Signed) _____

(Address) _____, 191____

*State the Disease Causing Death, or, in deaths from Violent Causes,
(1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT
RECENT RESIDENTS)

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

Where was disease contracted
if not at place of death?

Former or
usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied, so that it may be properly classified. 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.

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MARGIN RESERVED FOR BINDING