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: Lawrence

Township: Pierce

or Village: Pierce

or City: ~~Duroc~~ (NO. ..... St.: ..... Ward)

Registration District No. 471

Primary Registration District No. 5634

File No. 1 32315

Registered No. 193

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

FULL NAME: Lidey Manley

PERSONAL AND STATISTICAL PARTICULARS

SEX: female

COLOR OR RACE: White

~~SINGLE~~ ~~MARRIED~~ ~~WIDOWED~~ OR DIVORCED (~~Write the word~~)

DATE OF BIRTH: April (Month) 26 (Day), 1878 (Year)

AGE: 39 yrs. ..... mos. ..... ds.

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

OCCUPATION
(a) Trade, profession, or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): —— 23

BIRTHPLACE (City or town, State or foreign country): Sweden

PARENTS

NAME OF FATHER: Carl Carlson

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

MAIDEN NAME OF MOTHER: Mathilda Olson

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Ed Howard

(ADDRESS) Pierce City Mo

Filed 9-24, 1917. J. E. Barnhill REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Sept (Month) 24 (Day), 1917 (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 5.50 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

A

Dead when I arrived

(Duration) 2 yrs. ..... mos. ..... ds.

Contributory (SECONDARY) 28

8 (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Barnhill M. D.

9-23, 1917 (Address) Pierce City 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: Pierce City Mo

DATE OF BURIAL: Sept 25, 1917

UNDERTAKER: John Seufert

ADDRESS: Pierce City Mo

Revised United States Standard Certificate of Death

MISSOURI STATE BOARD OF
BUREAU OF VITAL STATIST
CERTIFICATE OF DEATH

PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No ..... Registered No. .....

or

City ..... (NO. ..... St.: ..... Ward) [If de hospita give it of stre

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

..... (Month) ..... (Day), 1..... (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) (D

I HEREBY CERTIFY, that I attended de

....., 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:

.....

.....

.....

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

Contributory .....
(SECONDARY)

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

(Signed) .....

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

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

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

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

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

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL | DATE OF BU

UNDERTAKER | ADDRESS

"Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc.,