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 Pettis

Township ____ or Village ____ or City Sedalia (NO. ____, ____ St.; ____ Ward)

Registration District No. 668 File No. 32745

Primary Registration District No. 3032 Registered No. 245

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

FULL NAME Doclie Savage

**PERSONAL AND STATISTICAL PARTICULARS**

SEX F

COLOR OR RACE W

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

DATE OF BIRTH Apr 16, 917 (Month) (Day) (Year)

AGE ____ yrs. 4 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) Mo

PARENTS
NAME OF FATHER C F Savage
BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo
MAIDEN NAME OF MOTHER Lillie Clark (E)
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE:

(Informant) Thos C F Savage

(ADDRESS) Sedalia Mo

Filed Sept 11, 1917 F B Long REGISTRAR

per E. T. Deputy

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH Sept 7, 1917 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 6, 1917, to Sept 7, 1917, that I last saw her alive on Sept 7, 1917, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

119B Meningitis
79A
(not epidemic) 61

(Duration) ____ yrs. ____ mos. 1 ds.

Contributory (SECONDARY) Enteritis

(Duration) ____ yrs. ____ mos. 4 ds.

(Signed) Frank Morley M. D.

Sept 8, 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 Crown Hill

DATE OF BURIAL Sep 7, 1917

UNDERTAKER Staley Undt

ADDRESS Sedalia Mo

PLACE OF DEATH

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

County _____

Township _____ Registration District No. _____ File No. _____

or

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

or

City _____ (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 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) _____ (Day) _____, 191__ (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:

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____ (SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191__ (Address) _____

*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 _____, 191__ |
|---|---|
| UNDERTAKER | ADDRESS |