

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 Smithton
Village
or
City (NO. St.; Ward)

Registration District No. 669 File No. 32750-a
Primary Registration District No. 3892 Registered No. 26

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

FULL NAME Anna Ruby Ellison

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>single</u>
DATE OF BIRTH <u>Sept 15</u> , 1917 (Month) (Day) (Year)		
AGE yrs. mos. <u>14</u> 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) <u>Mo</u>		

PARENTS	NAME OF FATHER <u>Chas Ellison</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo</u>
	MAIDEN NAME OF MOTHER <u>Rachel Lindsay</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. Ellison
(ADDRESS) Smithton

Filed Sept 30, 1917 S. M. Parrish
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
Sept 29, 1917
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from
Sept 15, 1917, to Sept 29, 1917,
that I last saw him alive on Sept 29, 1917,
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:

Circulatory Disturbance
and poor Nutrition
158

(Duration) 15 yrs. 1 mos. 1 ds.
Contributory
(SECONDARY)
(Duration) yrs. mos. ds.
(Signed) S. M. Parrish M. D.
Sept 30, 1917 (Address) Smithton

*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
Smithton

DATE OF BURIAL
Sept 30, 1917

UNDERTAKER
Newmeyer

ADDRESS
Smithton Mo

PLACE OF DEATH

County _____
 Township _____
 or _____
 Village _____
 or _____
 City _____

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

(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 (If write 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) _____

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

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

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.

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,

that I last saw him _____ alive on _____, 191____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH was as follows:

Contributory

(SECONDARY)

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

(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. 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

UNDERTAKER

ADDRESS