

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.

PLACE OF DEATH			MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH				
County	<u>Lewis</u>		Registration District No.	<u>498</u>	File No.	<u>38735</u>	
Township	<u>Highland</u>		Primary Registration District No.	<u>4287</u>	Registered No.	<u>307</u>	
or							
Village	<u>Living</u>						
or							
City			(NO. _____)	St. _____	Ward _____	(If death occurred in a hospital or institution, give its NAME instead of street and number)	
FULL NAME			<u>John H. Abell</u>				
PERSONAL AND STATISTICAL PARTICULARS						MEDICAL CERTIFICATE OF DEATH	
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)		DATE OF DEATH			
<u>Male</u>	<u>White</u>	<u>Married</u>		<u>Nov.</u>			
DATE OF BIRTH				(Month) _____ (Day) _____ (Year) _____			
<u>July 1, 1861</u>							
AGE				IF LESS than			
<u>56 yrs. 4 mos. 7 ds.</u>				1 day, _____ hrs. or _____ min.?			
OCCUPATION				I HEREBY CERTIFY, that I attended deceased from			
(a) Trade, profession, or particular kind of work <u>Farming</u>				<u>Nov 5, 1917, to Nov 7, 1917,</u>			
(b) General nature of industry, business, or establishment in which employed (or employer) <u>1180</u>				that I last saw him alive on <u>Nov 7, 1917,</u>			
BIRTHPLACE				and that death occurred, on the date stated above, at <u>7 a.m.</u>			
(City or town, State or foreign country) <u>Lewis Co Mo</u>				The CAUSE OF DEATH* was as follows:			
PARENTS	NAME OF FATHER		<u>Diabetic Ed acute</u>				
	BIRTHPLACE OF FATHER		<u>Indigestion</u>				
	MAIDEN NAME OF MOTHER		<u>60</u>				
	BIRTHPLACE OF MOTHER						
				(Duration) _____ yrs. _____ mos. _____ ds.			
				Contributory (SECONDARY) <u>Diabetic Gradual</u>			
				<u>arise.</u> (Duration) <u>not known</u>			
				(Signed) <u>W. H. Custer</u> M. D.			
				<u>Nov 7, 1917</u> (Address) <u>Burham Mo</u>			
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE				*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.			
(Informant) <u>J. N. Killbren</u>				LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)			
(ADDRESS) <u>Burham Mo</u>				At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.			
Filed <u>Nov 8, 1917</u> <u>Ch. F. Lane</u>				Where was disease contracted. If not at place of death?			
REGISTRAR				Former or usual residence _____			
				PLACE OF BURIAL OR REMOVAL			
				<u>Burham</u>			
				UNDERTAKER			
				<u>McLeish</u>			
				DATE OF BURIAL			
				<u>Nov 9, 1917</u>			
				ADDRESS			
				<u>Wagon</u>			

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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. _____

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 file the word)
DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)		
AGE _____ yrs. _____ mos. _____ ds. IF LESS than _____ hrs. _____ 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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____ (Year) 191 _____

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.

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

(Signed) _____ (Address) _____ 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 _____