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

Dr Walsh

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

County Putnam

Township ____ or Village ____ or City Unionville (NO. ____ St.: ____ Ward)

Registration District No. 1668 Primary Registration District No. 3032

File No. 39054 Registered No. 307

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

FULL NAME Infant Daughter Edward Wilkerson

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Nov (Month) 22 (Day) 1917 (Year)

AGE ____ yrs. ____ mos. 1 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) 15½ 15

BIRTHPLACE (City or town, State or foreign country) Mo

PARENTS

NAME OF FATHER Clem Wilkerson

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

MAIDEN NAME OF MOTHER Elizabeth A Bunnon

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C Wilkerson

(ADDRESS) Unionville Mo

Filed Nov 24 1917 F B Long REGISTRAR per E. J. Deputy

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov (Month) 22 (Day) 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 22, 1917, to Nov 22, 1917, that I last saw her alive on Nov 22, 1917, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Pts Failure of closing of foramen Ovale.

18 hrs.

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

Contributory (SECONDARY) Premature Birth 7½ mos

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

(Signed) W. T. Walsh M. D.

11/22 1917 (Address) Bevier 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 Woodlawn | DATE OF BURIAL Nov 23 1917

UNDERTAKER Utley Music | ADDRESS Unionville Mo

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
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 death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME.....

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

....., 1.....
(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 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