LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County Pike

Township ~~Ashley~~ or Village or City Ashley

Registration District No. 683 File No. 39089

Primary Registration District No. 4467 Registered No.

(NO. St.; Ward)

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

2 FULL NAME Ford Holiday

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Cool

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): married

6 DATE OF BIRTH: unknown (Month) (Day) 1 (Year)

7 AGE: 67 yrs. 6 mos. — ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry business, or establishment in which employed (or employer):

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

PARENTS

10 NAME OF FATHER: unknown

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

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. G. Michie

(Address) Ashley Mo

15

Filed Nov 26, 1917 J. E. Rees Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov (Month) 5 (Day), 1917 (Year)

17 I HEREBY CERTIFY, that I attended deceased from July 1, 1917, to Nov 5, 1917, that I last saw him alive on Nov 1, 1917, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Paresis

83 67

(Duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

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

(Signed) T. H. Wilcoxon M. D.

11/6/ 1917 (Address) Bowling Green Mo

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 2 yrs. 6 mos. ..... ds. In the State 67 yrs. 6 mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence Pike Co

19 PLACE OF BURIAL OR REMOVAL: Ashley

DATE OF BURIAL: Nov 5, 1917

20 UNDERTAKER: Tinsley & Bankhead

ADDRESS: B Green Mo

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.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

Revised United States Standard

1 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 hospital or institu give its NAME in of street and numb

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day) ..... 1..... (Year)

7 AGE

..... yrs. ..... mos. ..... ds.

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

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

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

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day) ..... 191..... (Y

17 I HEREBY CERTIFY, that I attended deceased f

....., 191....., to ....., 191..

that I last saw h..... alive on ....., 191..

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

The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

CONTRIBUTORY .....
(Secondary)

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

(Signed) ..... M

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

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

"Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("Pneumonia" unqualified is indefinite)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transie or Recent Residents)

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

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

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

..... 191

20 UNDERTAKER

ADDRESS