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.

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

PLACE OF DEATH

County Barton

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

Registration District No. 40

Primary Registration District No. 4024

File No. 40495

Registered No. 44

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

FULL NAME Jane Morrison

PERSONAL AND STATISTICAL PARTICULARS

SEX Female

COLOR OR RACE Whit

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widow

DATE OF BIRTH 2 (Month) 17 (Day), 1839 (Year)

AGE 78 yrs. 9 mos. 16 ds.

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

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

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

PARENTS

NAME OF FATHER Rich. Coolier

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

MAIDEN NAME OF MOTHER M Bales

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Mary E Backett

(ADDRESS) Lamar Mo.

Filed Dec 5, 1917 H Humphrey Dep REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 2 (Month) (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 29, 1917, to Dec 2, 1917, that I last saw her alive on Dec 1st, 1917, and that death occurred, on the date stated above, at 4a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

108

(Duration) ____ yrs. ____ mos. 5 ds.

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

(Signed) G D Allee M. D.

Dec 3, 1917 (Address) Lamar 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 Lake Cemetery Lamar Mo

DATE OF BURIAL Dec 5, 1917

UNDERTAKER Hoyt Humphrey

ADDRESS Lamar Mo

MISSOURI STATE BOARD OF H
BUREAU OF VITAL STATISTIC
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 deat hospital give its of street :

FULL NAME _____

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

_____ (Month) (D

I HEREBY CERTIFY, that I attended de

_____, 191__, to _____

that I last saw h_____ alive on _____

and that death occurred, on the date stated above,

The CAUSE OF DEATH* was as follows:

_____

_____

_____ (Duration) _____ yrs. _____ mos

Contributory _____
(SECONDARY)

_____ (Duration) _____ yrs. _____ mos

(Signed) _____

_____, 191__ (Address) _____

*State the Disease Causing Death, or, in deaths from Violen (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TR RECENT RESIDENTS)

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

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

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BU
UNDERTAKER	ADDRESS

as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic