LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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.

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

1 PLACE OF DEATH

County Chariton

Township Cockrell
or
Village
or
City (NO. St. Ward)

Registration District No. 960 File No. 40881

Primary Registration District No. 5247 Registered No. 16

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

2 FULL NAME not named (Price)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH November 28 1917 (Month) (Day) (Year)

7 AGE ..... yrs. ..... mos. 3 ds.

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

8 OCCUPATION
(a) Trade, profession, or particular kind of work — 156
(b) General nature of industry business, or establishment in which employed (or employer) —

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

PARENTS

10 NAME OF FATHER Jas. R. Price

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

12 MAIDEN NAME OF MOTHER Willie Scott

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. R. Price

(Address) Musselfork Mo

15 Filed Dec 1 1917 Chas. A. Clarkson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 1st 1917 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov. 28 1917, to Dec. 1st 1917, that I last saw her alive on Nov 30 1917, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows: Like of vitality and general feebleness was one of triplets

(Duration) 1 yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....

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

(Signed) Henry Gray M. D.

Dec. 1st 1917 (Address) Prairie Hill 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 ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL McCurry Cem.

DATE OF BURIAL Dec 2 1917

20 UNDERTAKER W. D. Cooper

ADDRESS Prairie Hill Mo

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 .....

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.]

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

.....; 191.....
(Month) (Day) (Year)

17 **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.**

18 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.....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

....., 191.....

20 UNDERTAKER

ADDRESS

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