LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

E

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

42213

1 PLACE OF DEATH

County Pemiscot

Township or Village or City Caruthersville, Mo. (No. ..... St.: ..... Ward)

Registration District No. 651 File No. .....

Primary Registration District No. 4388 Registered No. 254

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

2 FULL NAME Not named.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX girl

4 COLOR OR RACE white

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

6 DATE OF BIRTH December (Month) 9 (Day) 1917 (Year)

7 AGE 12 hrs. ..... 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) Caruthersville, Mo.

PARENTS

10 NAME OF FATHER Oliver Okeane

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Gibson Co. Tenn.

12 MAIDEN NAME OF MOTHER Maude Carter

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) O. O. Kane

(Address) Caruthersville Mo

15

Filed 12-9, 1917 B. D. Crane Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December (Month) 9th (Day) 1917 (Year)

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

The CAUSE OF DEATH* was as follows:

1581 Lethal only 5 or 6 hours Cause of death not known

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

~~CONTRIBUTORY~~ (Secondary) J. B. Lutin

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

(Signed) Caruthersville M. D.

12-9-1917 (Address) 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 Caruthersville Mo

DATE OF BURIAL Dec 10, 1917

20 UNDERTAKER J. R. Lewis

ADDRESS Caruthersville 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.

...PLAIN UNFADING INK—THIS IS A PERMANENT RECORD

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF H
BUREAU OF VITAL STATISTIC
CERTIFICATE OF DEATH

Revised United States Standard Certificate of Death

Approved by U. S. Census and American Public Health

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 dea hospital, give its of street

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)

17 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, at

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) .....yrs. ..... mo

CONTRIBUTORY .....
(Secondary)

..... (Duration) .....yrs. ..... mo

(Signed) .....

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

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, or 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 .....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BUR

20 UNDERTAKER

ADDRESS

"Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor"