

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
County Wettin
Township _____
or
Village _____
or
City Idalia (NO. _____ St.; _____ Ward)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH **42258**

Registration District No. 668 File No. _____
Primary Registration District No. 3032 Registered No. 319

FULL NAME Bertha M Wild

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

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE W SINGLE Single
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH Nov 29 1886
(Month) (Day) (Year)

AGE 31 yrs. _____ mos. _____ ds. IF LESS than
1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Nothing
(b) General nature of industry, business, or establishment in which employed (or employer) _____

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

NAME OF FATHER B L Wild

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

MAIDEN NAME OF MOTHER Mary Wahl

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B L Wild

(ADDRESS) Idalia Mo

Filed Dec. 4 1917 F B Lora
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from Nov 1st, 1917, to Dec 2nd, 1917, that I last saw her alive on Nov 29th, 1917, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia
16
10:1 A

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory ed paralysis, chest
(SECONDARY) complete
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. K. Kollig M. D.
Dec 4th 1917 (Address) Idalia, 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 Crown Hill DATE OF BURIAL 12-3- 1917

UNDERTAKER Edith Wm & Co ADDRESS Idalia

Per E. J. Murphy

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

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

PLACE OF DEATH

County _____
Township _____
or _____
Village _____
or _____
City _____ (NO. _____)
Registration District No. _____
Primary Registration District No. _____
Registered No. _____
File No. _____

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

St. _____ Ward _____

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____ COLOR OR RACE _____
SINGLE _____ MARRIED _____
WIDOWED _____ OR DIVORCED _____
(If write the word)

DATE OF BIRTH _____ (Day) _____ (Month) _____ (Year) _____
AGE _____ yrs. _____ mos. _____ ds. _____

IF LESS than 1 day, _____ hrs. _____ 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) _____

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) _____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____, 191 _____, to _____, 191 _____, that I last saw him 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) _____

(Address) _____ 191 _____ M. D.

*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 _____