PLACE OF DEATH

County Laclede

Township Gasconade

or

Village

or

City (NO. , St.; Ward)

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

Registration District No. 453

File No. 1855

Primary Registration District No. 5619

Registered No.

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

FULL NAME Clement Nathan Ricks

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: Oct. (Month) 4 (Day), 1884 (Year)

AGE: 33 yrs. 3 mos. 7 ds.

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

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE (City or town, State or foreign country): Lincoln Co. Mo.

PARENTS

NAME OF FATHER: Joshua H. Ricks

BIRTHPLACE OF FATHER (City or town, State or foreign country): Lincoln Co. Mo.

MAIDEN NAME OF MOTHER: Melvina Groshong

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Lincoln Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Job Anderson

(ADDRESS) Southard Mo

Filed Jan. 13, 1918. Dr. L. D. Hartley REGISTRAR

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MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Jan. (Month) 11 (Day), 1918 (Year).

I HEREBY CERTIFY, that I attended deceased from Dec. 2, 1917, to Jan. 11, 1918, that I last saw him alive on Jan. 11, 1918, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

129

(Duration) yrs. mos. ds.

Contributory (SECONDARY) Peritonitis

(Duration) yrs. mos. 2 ds.

(Signed) Dr. L. D. Hartley M. D.

Jan 11, 1918 (Address) Neb 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 Southard Mo.

PLACE OF BURIAL OR REMOVAL: Macidona

DATE OF BURIAL: Jan. 13, 1918

UNDERTAKER: John Pond

ADDRESS: Southard Mo.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
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 death occurred in a hospital or institution, give its NAME instead of street and number]

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

_____, *191*____
(Month) (Day) (Year)

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.

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