

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 Pettis
Township Houstonia
or
Village Houstonia, Mo.
or
City _____ (NO. _____ St. _____ Ward _____)

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

Registration District No. 665 File No. 14191
Primary Registration District No. 5883 Registered No. 20

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

FULL NAME

William P. Alexander

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED <u>Married</u> WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>July 15, 1886</u> (Month) (Day) (Year)		
AGE <u>51 yrs. 8 mos. 16 ds.</u>		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) Houstonia Mo.

PARENTS	NAME OF FATHER <u>James Alexander</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Kentucky</u>
	MAIDEN NAME OF MOTHER <u>Mary Revis</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo.</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. W. R. Alexander
(ADDRESS) Houstonia Mo.

Filed 4-16 1918 J. A. Smith M.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Apr 11, 1918
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug, 1918, to Apr 11, 1918, that I last saw him alive on Apr 11, 1918, and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy
824
97 64

(Duration) 4 yrs. ____ mos. ____ ds.

Contributory Arteriosclerosis
(SECONDARY) (Duration) 10 yrs. ____ mos. ____ ds.

(Signed) C. L. Parkhurst, M. D.
Apr 12, 1918 (Address) Houstonia

*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 <u>Houstonia, Mo.</u>	DATE OF BURIAL <u>4-13</u> , 191 <u>8</u>
UNDERTAKER <u>F. C. Voigt</u>	ADDRESS <u>Houstonia</u>

PLACE OF DEATH

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

County _____
Township _____
or _____
Village _____
or _____
City _____

Registration District No. _____
Primary Registration District No. _____
Registered No. _____
St. _____ Ward _____
(NO. _____)

(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 (If file the word)
DATE OF BIRTH	(Month)	(Day) (Year)
AGE	_____ yrs.	_____ mos. _____ ds.
OCCUPATION	(a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)	

DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year) _____

AGE _____ yrs. _____ mos. _____ ds.

OCCUPATION _____

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 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) _____, 191____ (Address) _____ 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. 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 _____

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.