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

PLACE OF DEATH

County Ozark

Township Lick Creek
or
Village
or
City (NO. St.; Ward)

Registration District No. 645 File No. 424068

Primary Registration District No. 6273 Registered No. 1

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

FULL NAME Mary Ellon Baxter

PERSONAL AND STATISTICAL PARTICULARS

SEX Femal COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

DATE OF BIRTH May (Month) 12 (Day) 1851 (Year)

AGE 67 yrs. 2 mos. 6 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) House Wifery

BIRTHPLACE (City or town, State or foreign country) Murry Co Ten

PARENTS
NAME OF FATHER Bengaman F Watts
BIRTHPLACE OF FATHER (City or town, State or foreign country) Kentucky
MAIDEN NAME OF MOTHER Nancy Robertson
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Tennessee 8

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. B. Baxter

(ADDRESS) Howards Ridge

Filed July 23 1918. S. B. Baxter REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July (Month) 18 (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from , 191 , to , 191 , that I last saw her alive on 18th of July, 1918, and that death occurred, on the date stated above, at 12 a m.

The CAUSE OF DEATH* was as follows:

I saw patient about 2 hours before she died Cause of death Chronic Malaria (Duration) yrs. mos. 9 ds.

Contributory (SECONDARY) OK (Duration) yrs. mos. ds.

(Signed) J. T. White M. D.

July 21, 1918 (Address) Gainesville Md

*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 Howard Ridge DATE OF BURIAL July 19, 1918

UNDERTAKER John Morgan ADDRESS Howard Ridge

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

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.