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

1 PLACE OF DEATH

County .....

Township ..... or Village ..... or City St. Louis Mo (NO. Mo. Baptist S St.; 75 Ward)

Registration District No. 791 File No. 30605

Primary Registration District No. 1003 Registered No. 8501

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

2 FULL NAME Ollie May, Emerson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: Oct. (Month), 11 (Day), 1875 (Year)

7 AGE: 42 yrs. 10 mos. 29 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer): at Home

9 BIRTHPLACE (City or town, State or foreign country): Cape Girardeau Co Mo

PARENTS

10 NAME OF FATHER: James P Sith

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

12 MAIDEN NAME OF MOTHER: Rilah Shinkard

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): J. O. Smith

(Address): Morley Mo

15 Filed SEP 20 191 191 Max C. Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept 10 (Month) (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 6, 1918, to Sept 10, 1918, that I last saw her alive on Sept 10, 1918, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction and Solar pneumonia following surgical operation

(Duration) 9 yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary): Solar Pneumonia & Int. obstruction

(Duration) — yrs. — mos. 10 hours ds.

(Signed) W. Murray Winn M. D.

9-10, 1918 (Address) Mo. Baptist Sanitar

*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. 5 ds. In the State 42 yrs. — mos. — ds.

Where was disease contracted if not at place of death?

Former or usual residence: Morley Mo.

19 PLACE OF BURIAL OR REMOVAL: Morley, Mo

DATE OF BURIAL: Sept 11, 1918

20 UNDERTAKER: M. H. Alexander

ADDRESS: 2835 Olive

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

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 death occurred in hospital or institution give its NAME instea of street and number.]

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

....., 1..... (Month) (Day) (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

....., 191..... (Month), (Day) (Year

17 I HEREBY CERTIFY, that I attended deceased fro

....., 191....., to....., 191.....

that I last saw h.....alive on....., 191.....

and that death occurred, on the date stated above, at.....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos.....d

CONTRIBUTORY .....
(Secondary)

..... (Duration).....yrs.....mos.....d

(Signed).....M. I

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

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transient or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....d

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191..
20 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. Exact statement of OCCUPATION is very important.

CAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT