MARGIN RESERVED FOR BINDING

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

1 PLACE OF DEATH

County Greene

Township ..... Registration District No. 318 File No. 32990a

or

Village ..... Primary Registration District No. 2001 Registered No. 809

or

City Springfield Mo (No. 1824 N Jefferson St.; ..... Ward)

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

2 FULL NAME Dally Johnston

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 Feb (Month) 16 (Day) 1890 (Year)

7 AGE 28 yrs. 8 mos. 15 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) .....

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

PARENTS

10 NAME OF FATHER W S Medlock

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

12 MAIDEN NAME OF MOTHER Francis Finley

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo A Johnston

(Address) 1824 N Jefferson St

15 Filed NOV 1 1918 191 Edison F James Registrar

Dollie B Johnson Deputy Registrar

Shippee Nov 2 1918

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 10/ 1 (Month) ..... (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from 10/26, 1918, to 11-1, 1918, that I last saw her alive on Oct 31, 1918, and that death occurred, on the date stated above, at 1 30 a m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

11 A

10 A

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) ..... yrs. ..... mos. 8 ds.

(Signed) S F Freeman M. D.

11/1, 1918 (Address) Springfield Mo

*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. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

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

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Conway Mo

DATE OF BURIAL ....., 191

20 UNDERTAKER J W Klingner & Co

ADDRESS Springfield Mo

Permit not returned

V. S. No. 2. A

MARGIN RESERVED FOR BINDING

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

1 PLACE OF DEATH

County .....

Township ..... or Village ..... or City ..... (NO. ....., ... St.; ..... Ward)

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

[If death occurred in a hospital or institution, give its NAME instead 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

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

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

17 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.

18 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 .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS