LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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 Nodaway

Township Independence

or

Village

or

City Pamell Mo (NO. ..... St.; ..... Ward)

Registration District No. 626 File No. 34975

Primary Registration District No. 4375 Registered No. .....

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

2 FULL NAME Claud Nelson Alexander

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

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

6 DATE OF BIRTH April 24 (Month) (Day) 1879 (Year)

7 AGE 39 yrs. 6 mos. 4 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Tamer
(b) General nature of industry business, or establishment in which employed (or employer) —

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

PARENTS

10 NAME OF FATHER Theodore W Alexander

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

12 MAIDEN NAME OF MOTHER Katie Langford

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Theodore W Alexander

(Address) King City Mo

15 Filed Oct 29, 1918 Hiram Dry M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 28. (Month) (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 15, 1918, to Oct 28, 1918, that I last saw him alive on Oct 28, 1918, and that death occurred, on the date stated above, at 3 30 p.m.

The CAUSE OF DEATH* was as follows:

Influenza & Lobar Pneumonia

114

108

10

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

CONTRIBUTORY (Secondary) .....

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

(Signed) L. O. Nye M. D.

Oct 29, 1918 (Address) Pamell

*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 Pamell Mo DATE OF BURIAL Oct 29, 1918

20 UNDERTAKER Roof LaFarm ADDRESS Pamell Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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 a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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 .....