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 .....

Township ..... Registration District No. 701 File No. 36[illegible]

or

Village ..... Primary Registration District No. 1008 Registered No. 9967

or

City St. Louis Mo. (No. Isolation Hosp. St.; 24 Ward)

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

2 FULL NAME Adolphus Damon Wilburn

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: Mar (Month) 17 (Day), 1880 (Year)

7 AGE: 38 yrs. 7 mos. 4 ds. If LESS than 1 day, ...hrs. or ....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): Men Ave Hat Co.

9 BIRTHPLACE (City or town, State or foreign country): Lake City, Miss

PARENTS

10 NAME OF FATHER: J. C. Wilburn

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

12 MAIDEN NAME OF MOTHER: Agnes Downon

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Irene Bullock
(Address) Isolation Hosp.

15 Filed OCT 22 1918, 191 Mary C. Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 10 (Month) 21 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from 10-13, 1918, to 10-21, 1918, that I last saw him alive on 10-21, 1918, and that death occurred, on the date stated above, at 4 am m.

The CAUSE OF DEATH* was as follows:

Influenza 10

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

CONTRIBUTORY (Secondary) Bronchio pneumonia

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

(Signed) Allison Neale M. D.

10-21, 1918 (Address) Isolation Hospital

*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. 8 ds. In the State ....yrs. ....mos. 7 ds.

Where was disease contracted if not at place of death? Do not Kind

Former or usual residence Warwick Hotel

19 PLACE OF BURIAL OR REMOVAL: Laurel Miss

DATE OF BURIAL: Octo 21, 1918

20 UNDERTAKER: Wagoner

ADDRESS: 3621 Ole

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 .....

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

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.