

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHCounty Stone

Township _____

or Galena Mo.

Village _____

or _____

City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 843File No. 37500Primary Registration District No. 4513

Registered No. _____

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

FULL NAME

Mrs. Audie Blythe

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE Single
MARRIED
WIDOWED
OR DIVORCED
(Write the word)DATE OF BIRTH Sept. 27, 1905
(Month) (Day) (Year)AGE 13 yrs. 27 mos. 27 ds.
IF LESS than
1 day, ____ hrs.
or ____ min.?OCCUPATION
(a) Trade, profession, or particular kind of work In school
(h) General nature of industry, business, or establishment in which employed (or employer) _____BIRTHPLACE
(City or town, State or foreign country) Mo.NAME OF FATHER Absalom H. BlytheBIRTHPLACE OF FATHER
(City or town, State or foreign country) Mo.MAIDEN NAME OF MOTHER Hattie C. CagleBIRTHPLACE OF MOTHER
(City or town, State or foreign country) Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. H. Blythe(ADDRESS) Galena Mo.Filed Nov. 1, 1918, H. Henson

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct. 24, 1918
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Oct. 14, 1918, to Oct. 24, 1918,
that I last saw h.s. alive on Oct. 24, 1918,
and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

11 A Influenza10 1/2 (Duration) yrs. 10 mos. 10 ds.Contributory (SECONDARY) Pneumonia
(Duration) yrs. 6 mos. 6 ds.(Signed) H. Henson M. D.
Oct 24, 1918 (Address) Galena Mo.

*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 Galena Cemetery DATE OF BURIAL Oct 25, 1918UNDERTAKER Craig Murr. Co. ADDRESS Galena Mo.

PLACE OF DEATH

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

County _____
Township _____
or _____
Village _____
or _____
City _____

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

(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 _____
(If file the word)

DATE OF BIRTH _____
(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)

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 _____

(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 _____
The CAUSE OF DEATH* was as follows:

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

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

(Signed) _____ M. D.

(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 _____