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

PLACE OF DEATH

County: Cooper

Township: Blackwater

or

Village:

or

City: (NO. St.: Ward)

Registration District No. 217 File No. 38756

Primary Registration District No. 5297 Registered No.

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

FULL NAME: William T Asbury

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

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

DATE OF BIRTH: May (Month) 1st (Day) 1859 (Year)

AGE: 59 yrs. 6 mos. 13 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE (City or town, State or foreign country): Knox Co Mo

PARENTS

NAME OF FATHER: Unknown

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

MAIDEN NAME OF MOTHER: Unknown

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Mrs Gladys McClain His Daughter

(ADDRESS):

Filed: Dec 10, 1918. M R Huffman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Nov (Month) 14 (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 10, 1918, to Nov 14, 1918, that I last saw him alive on Nov 14, 1918, and that death occurred, on the date stated above, at about 7:00 m.

The CAUSE OF DEATH* was as follows:

Influenza & Double Pneumonia

11A 10B (Duration) ___ yrs. 10 mos. Nov ds.

Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) [signature] M. D.

Dec 18, 1918 (Address) Nelson 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: Salt Fork Cemetery

DATE OF BURIAL: Nov 16, 191[illegible]

UNDERTAKER: Irvin & Day

ADDRESS: Blackwater Mo

PLACE OF DEATH

MISSOURI STATE BOARD OF HEAL
BUREAU OF VITAL STATISTICS
CERTIFICATE 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 hospital or instit give its NAME in of street and numbe

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., 1.....
(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)

PARENTS

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

....., 19
(Month) (Day) (Y

I HEREBY CERTIFY, that I attended deceased

....., 191...., to....., 19

that I last saw h.....alive on....., 19

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

The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

Contributory.....
(SECONDARY)

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

(Signed).....

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

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT RECENT RESIDENTS)

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

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

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 1
UNDERTAKER	ADDRESS