LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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. 39176

or

Village ..... Primary Registration District No. 2001 Registered No. 832 (832)

or

City Springfield, Mo (NO. 416½ Convention Ave St.; 3rd Ward)

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

2 FULL NAME B. F. Cole

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 Nov (Month) 7 (Day), 1869 (Year)

7 AGE 48 yrs. 11 mos. 4 ds.

If LESS than 1 day, ... hrs. or ..... min.?

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

9 BIRTHPLACE (City or town, State or foreign country) DeWitt Co. Ill

PARENTS

10 NAME OF FATHER Thos Cole

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

12 MAIDEN NAME OF MOTHER Martha Fentres

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Martha Fentres
416½ Convent in Ave.
(Address) Springfield, Mo.

15 NOV 12 1918
Filed ....., 191.. Edwin F. James Registrar
Dollie B Johnson
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov (Month) 11th (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from 11-5, 1918, to 11-11, 1918, that I last saw him alive on 11-10, 1918, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Influenza
80
113
10

..... (Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Locomotor Ataxia and rosal (spinal) adjustment by a Chiropractor (Duration) 3 yrs. ..... mos. ..... ds.

(Signed) W. M. F. Brown M. D.

Nov 11, 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 East Lawn Cemetery

DATE OF BURIAL 11-12, 1918

20 UNDERTAKER Taxson Und Co

ADDRESS 410 South St

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

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.