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: Greene

Township: ..... or Village: ..... or City: Springfield Mo (No. 319 Kansas Ave. St., ... Ward)

Registration District No. 318 Primary Registration District No. 2001

File No. 39199 Registered No. 855 (855)

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

2 FULL NAME: Infant of Mr. & Mrs. Claude Bogar

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Infant

6 DATE OF BIRTH: Nov. 21 (Month) (Day) 1918 (Year)

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

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

9 BIRTHPLACE (City or town, State or foreign country): Mo.

PARENTS

10 NAME OF FATHER: Claude Lee Bogar

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

12 MAIDEN NAME OF MOTHER: Mary Bell Earls

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Claude W. Bogar
(Address): 319 Kansas Ave.

15 Filed NOV 23 1918, 191..
Edna F. James
Dollie B. Johnson Registrar
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov. 21 (Month) (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov 21 1918, to Nov. 21 1918, that I last saw him alive on Nov. 21 1918, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:
Prematurity
34
1 29
31
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Syphilis
(Duration) ... yrs. ... mos. ... ds.

(Signed) A. Armstrong M. D.
11-23 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: Hazelwood Cem. DATE OF BURIAL: 11-23 1918

20 UNDERTAKER: Blackwell Co. ADDRESS: Marshfield

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

....., 1.....
(Month) (Day) (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

....., 191.....
(Month) (Day) (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**