LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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 Jasper

Township ~~[illegible]~~ or

Village or City Webb City

Registration District No. 417 File No. 40410

Primary Registration District No. 3021 Registered No. 255

(No. Jasper Co. Tuber. Hosp. St.; Ward)

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

2 FULL NAME William H Malley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male ~~White~~

4 COLOR OR RACE White ~~Male~~

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Divorced

6 DATE OF BIRTH Unknown (Month) (Day) 1847 (Year)

7 AGE 71 yrs. mos. ds.

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

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

9 BIRTHPLACE (City or town, State or foreign country) Not Known

PARENTS

10 NAME OF FATHER Not Known

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

12 MAIDEN NAME OF MOTHER Not Known

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dessie Modglin

(Address) Carterville Mo

15 Filed Nov. 12, 1918 C. E. McBride

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov (Month) 12 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 25, 1918, to Nov. 12, 1918, that I last saw him alive on Nov 12, 1918, and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pul. Tuberculosis

(Duration) yrs. mos. ds.

(Signed) Leo A Stock M. D.

Nov 12, 1918 (Address) Webb City

*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. 1 mos. 18 ds. In the State yrs. mos. ds.

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

Former or usual residence Carthage Mo

19 PLACE OF BURIAL OR REMOVAL Carthage Mo

DATE OF BURIAL Nov 14, 1918

20 UNDERTAKER Knoll Und C[illegible]

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

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.....

UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.