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

File No. 2 41053

1 PLACE OF DEATH

County: New Madrid

Township: Anderson
or
Village:
or
City: Gideon (NO. ..... St.: ..... Ward)

Registration District No. 55

Primary Registration District No. 4033

Registered No. 57

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

2 FULL NAME: Ralph James

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: Oct (Month) 8 (Day) 1917 (Year)

7 AGE: 1 yrs. 8 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): Gideon MO

PARENTS

10 NAME OF FATHER: Herman James

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

12 MAIDEN NAME OF MOTHER: Retta Keys

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Herman James
(Address): Gideon MO

15
Filed 11-9, 1918. M. V. Munnerlyn
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov (Month) 8 (Day), 1918 (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 4 a.m.

The CAUSE OF DEATH* was as follows:
Died without Medical Attention
(Duration) ..... yrs. ..... mos. ..... ds.

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

(Signed) M. V. Munnerlyn L. R.
Nov 8, 1918 (Address) Gideon 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: Mt Gilead
DATE OF BURIAL: Nov 9, 1918

20 UNDERTAKER: J. W. Cresap
ADDRESS: Gideon MO

LOCAL REGISTRAR'S ... DO NOT TEAR LEAF OUT

1 PLACE OF DEATH

County .....

Township ..... Registration District
or
Village ..... Primary Registration
or
City ..... (NO. ....., ...

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

..... File No. .....

..... Registered No. .....

.....St.; .....Ward)

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

2 FULL NAME .....

WRITE PLAINLY WITH INK ...

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.

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