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 Midway

Township Independence Registration District No. 626 File No. 231203

or

Village ..... Primary Registration District No. 5828 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 Eva Ester Miller Robison

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~SINGLE~~ MARRIED ~~WIDOWED~~ ~~OR DIVORCED~~ (~~Write the~~ word): Married

6 DATE OF BIRTH: Feb 18 (Month) (Day), 1888 (Year)

7 AGE: 30 yrs. 8 mos. 27 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: 110
(b) General nature of industry business, or establishment in which employed (or employer): Wife. 98

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

PARENTS

10 NAME OF FATHER: J R Miller

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

12 MAIDEN NAME OF MOTHER: May Hubbard

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elmer Robison

(Address) Parnell Mo

15 Filed Nov 22, 1918, Hiram Dryden Registrar

MEDICAL CERTIFICATE OF DEATH

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

17 I HEREBY CERTIFY, that I attended deceased from Nov 11, 1918, to Nov 21, 1918, that I last saw her alive on Nov 20, 1918, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Influenza and Lobar Pneumonia

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

CONTRIBUTORY (Secondary) 10

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

(Signed) L O Nye M. D.

Nov 21, 1918 (Address) Parnell

*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: Ravenwood Mo

DATE OF BURIAL: Nov 22, 1918

20 UNDERTAKER: Roof & La Favor

ADDRESS: Parnell Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR DEAD 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 .....

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