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 41344

PLACE OF DEATH

County Pettis

Township Houstonia
or
Village
or
City (NO. St.; Ward)

Registration District No. 665 File No. 30

Primary Registration District No. 5885 Registered No. 31

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

FULL NAME Walter Raymond Charles

PERSONAL AND STATISTICAL PARTICULARS

SEX: male

COLOR OR RACE: white

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): single

DATE OF BIRTH: 9 (Month) 21 (Day), 1914 (Year)

AGE: 4 yrs. 1 mos. 16 ds.

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

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

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

PARENTS

NAME OF FATHER: Harry Charles

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

MAIDEN NAME OF MOTHER: Elva Hayworth

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry F. Charles.

(ADDRESS) Houstonia Mo.

Filed 11-10, 1918. T. A. Smith M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Nov (Month) 7 (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 16, 1918, to Nov 7, 1918, that I last saw him alive on Nov 7, 1918, and that death occurred, on the date stated above, at 6 P.m.

The CAUSE OF DEATH* was as follows:

11A 10
109A

Bronchial Pneumonia

(Duration) ___ yrs. ___ mos. 14 ds.

Contributory (SECONDARY) Hanish Influenza

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

(Signed) O. L. Parkhurst, M. D.

Nov 9, 1918 (Address) Houstonia

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

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

PLACE OF BURIAL OR REMOVAL: Houstonia Mo.

DATE OF BURIAL: 11-8, 1918

UNDERTAKER: F. C. Voigt

ADDRESS: Houstonia Mo.

PLACE OF DEATH

County .....

Township ..... or Village ..... or City .....

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

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

(NO. ..... St.; ..... Ward)

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

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

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

AGE

..... yrs. ..... mos. ..... ds.

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

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

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

MAIDEN NAME OF MOTHER

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... (Month) ..... (Day), 191..... (Year)

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.

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 .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
UNDERTAKER	ADDRESS

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD

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.