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.

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. 791 File No. 42936

or

Village ..... Primary Registration District No. 1008 Registered No. 11932

or

City Drs Lewright & Whitners Hs. Grand & 28th St (No. ..... St. ..... Ward)

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

2 FULL NAME Mary Solich

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE white

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

6 DATE OF BIRTH Nov (Month) 21 (Day), 1887 (Year)

7 AGE 31 yrs. ... mos. 1 ds. If LESS than 1 day, ... hrs. or ..... min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Austria

PARENTS

10 NAME OF FATHER John Unknown

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

12 MAIDEN NAME OF MOTHER Unknown

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr John Solich

(Address) Flat River Mo.

15 Filed NOV 23 1918 Max C Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov (Month) 22nd (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov 2nd 1918, to Nov 22, 1918, that I last saw her alive on Nov 22, 1918, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

01

(Duration) ..... yrs. ..... mos. 30 ds.

CONTRIBUTORY (Secondary) None

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

(Signed) A. P. Shellman M. D.

Nov 22, 1918 (Address) 2009 E Grand Ave

*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. 20 ds. In the State ..... yrs. ..... mos. 20 ds.

Where was disease contracted if not at place of death? Flat River Mo

Former or usual residence Flat River Mo

19 PLACE OF BURIAL OR REMOVAL E E Peter & Paul

DATE OF BURIAL Nov 23, 1918

20 UNDERTAKER E. J. Schmidt

ADDRESS 2652 Chouteau

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

..... (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

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.