LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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: Greene

Township: North Campbell — Registration District No. 318 — File No. 45539

or

Village: — Primary Registration District No. 5439 — Registered No. 952

or

City: Springfield Mo (NO. 1470 W Water St.; Ward)

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

2 FULL NAME: Ruth Kelley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

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

6 DATE OF BIRTH: June (Month) 17 (Day), 1900 (Year)

7 AGE: 18 yrs. 6 mos. 2 ds. — If LESS than 1 day, ...hrs. or ....min.?

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

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

PARENTS

10 NAME OF FATHER: S Kelley

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

12 MAIDEN NAME OF MOTHER: Lidia Ramey

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): S Kelley

(Address): 1470 W Water

15 Filed: DEC 20 1918, 191 — Edwin F. James, Registrar — Dallie B. Johnson

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 12 (Month) 19 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Dec 8, 1918, to Dec 19, 1918, that I last saw her alive on Dec 19, 1918, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Catarrhal)

107A

10

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary): Influenza

(Duration) ....yrs. ....mos. 4 ds.

(Signed) N A Weed M. D.

12-19, 1918 (Address) 7385 Sanders Blvd Springfield 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: Greenlawn Cem — DATE OF BURIAL: Dec 20, 1918

20 UNDERTAKER: Lohmeyer Und Co — ADDRESS: 300 W Water

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County: Greene

Township or Village or City: Springfield (No. 1470 N Water St.; Ward)

Registration District No.: ____ File No.: ____

Primary Registration District No.: ____ Registered No.: ____

(If death occurr hospital or inst give its NAME of street and nu

2 FULL NAME Ruth Kelley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

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

6 DATE OF BIRTH: June (Month) 17 (Day) 1900 (Year)

7 AGE: 18 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): Springfield Mo

PARENTS

10 NAME OF FATHER: S. Kelley

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

12 MAIDEN NAME OF MOTHER: Nelda Ramey

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): S. Kelley

(Address): 1470 N. Water

15

Filed ____, 191____, ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: ____ (Month) ____ (Day), 191

17 I HEREBY CERTIFY, that I attended deceased ____, 191____, to ____, 19____ that I last saw h____ alive on ____, 19____ and that death occurred, on the date stated above, at ____

The CAUSE OF DEATH* was as follows:

____ (Duration) ____ yrs. ____ mos.

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

(Signed) ____

____, 191____ (Address) ____

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos.

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

Former or usual residence ____

19 PLACE OF BURIAL OR REMOVAL: Green Lawn

DATE OF BURIAL: Dec 20, 19

20 UNDERTAKER: Downey & Wade

ADDRESS: 300 N Main

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