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

45547

1 PLACE OF DEATH

County Greene

Township North Campbell Registration District No. 318 File No.

or

Village Primary Registration District No. 1139 Registered No. 879

or

City Springfield Mo. 1317 Wabash (Ward)

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

2 FULL NAME Pearl Vandiver

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 February 11, 1905 (Month) (Day) (Year)

7 AGE 13 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Bado Mo. texas County

PARENTS

10 NAME OF FATHER W. Vandiver

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

12 MAIDEN NAME OF MOTHER Amelia Chancy

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. Vandiver

(Address) 1215 Wabash

15 Filed DEC 2 1918, 191 Edwin F. James Registrar
Dollie B. Johnson

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 1, 1918 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov 10, 1918, to Dec 1, 1918, that I last saw her alive on Dec 1, 1918, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Catarrhal Pneumonia

(Duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H A Stell M. D.

Dec 1, 1918 (Address) 738 Landers Bldg

*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

Permit not returned

19 PLACE OF BURIAL OR REMOVAL Mt. Grove Mo. DATE OF BURIAL 191

20 UNDERTAKER Lohmeyer ADDRESS 305 W Wal

LOCAL REGISTRAR'S RECORD

CORD

CIANS should state
N is very important.

EAR LEAF OUT

URI STATE BOARD OF HEALTH
UREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration Distri ..... 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

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

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