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 Co

Township: ~~Washington~~ or Village: or City: ~~Rogerville~~ (NO. R R #2 St.; Ward)

Registration District No. 321 File No. 45554

Primary Registration District No. 5444 Registered No. 28

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

2 FULL NAME Billie Louise Kelsay

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: Wh

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

6 DATE OF BIRTH: Sept. 14, 1918 (Month) (Day) (Year)

7 AGE: 1 yrs. 2 mos. 29 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): Rogerville Mo

PARENTS

10 NAME OF FATHER: Edward Kelsay

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

12 MAIDEN NAME OF MOTHER: Effie Hooper

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward Kelsay
(Address) Rogerville Mo

15
Filed Dec 7, 1918. W. L. Turner Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec 4, 1918 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Dec 19, 1918, to Dec 4, 1918, that I last saw her alive on Dec 4, 1918, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

61 (Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Probably Influenza (Duration) ....yrs. ....mos. 3 ds.

(Signed) W. L. Turner M. D.

Dec 4, 1918 (Address) Halloway

*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: Dodson Cem. DATE OF BURIAL: Dec 7, 1918

20 UNDERTAKER: Lohmeyer Und Co ADDRESS: 306 N Walnut Springfield

LOCAL REGISTRAR'S RECORD — DO NOT

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.

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

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

....., 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**