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

PLACE OF DEATH

County: Johnson

Township: Madison

or

Village:

or

City: (NO. , St.: Ward)

Registration District No. 427

Primary Registration District No. JJ-82

File No. 47139

Registered No. 101

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

FULL NAME Grace Edith Mitchell

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: white

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

DATE OF BIRTH: Mar. (Month) 1 (Day), 1917 (Year)

AGE: 1 yrs. 9 mos. 10 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): Holden Mo

PARENTS

NAME OF FATHER: Noble Mitchell

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

MAIDEN NAME OF MOTHER: Lucy Baldwin

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. M. E. Mitchell

(ADDRESS) Holden, Mo.

Filed Dec 9, 1918. G W Harris
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: 12 (Month) — 8 (Day) —, 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 2, 1918, to Dec 8, 1918, that I last saw her alive on 12-9, 1918, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Spanish influenza

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

Contributory (Secondary) Pneumonia

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

(Signed) P. L. Bills M. D.

12-10, 1918 (Address) Magnolia Mo

*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: New Liberty Magnolia

DATE OF BURIAL: Dec 10, 1918

UNDERTAKER: None

ADDRESS

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

PLACE OF DEATH

County _____

Township _____ *or* Village _____ *or* City _____

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