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

PLACE OF DEATH

County: Wright

Township: ~~Mountain Grove~~ RFD

or Village:

or City: Mountain Grove RFD

Registration District No. 908 File No. 51097

Primary Registration District No. 6222 Registered No. 79

(NO. ____ St.: ____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Olive Elida Hawley

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

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

DATE OF BIRTH: Jan 18, 1889 (Month) (Day) (Year)

AGE: 29 yrs. 10 mos. 24 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): Wright-Co

PARENTS

NAME OF FATHER: Edward Hawley

BIRTHPLACE OF FATHER (City or town, State or foreign country): Rensler Co N.Y.

MAIDEN NAME OF MOTHER: Mary Jane Tinman

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary J Hawley

(ADDRESS) Mountain Grove

Filed 12-17, 1918. J. M. Hubbard REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from Dec 2, 1918, to Dec 12, 1918, that I last saw her alive on Dec 12, 1918, and that death occurred, on the date stated above, at 3 45 p.m.

The CAUSE OF DEATH* was as follows:

1A Pneumonia 10
1B

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

Contributory (SECONDARY) Influenza

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

(Signed) H M Daugherty M. D.

____, 191__ (Address) Mountain Grove 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: Fairview Cem

DATE OF BURIAL: Dec 14, 1918

UNDERTAKER: H J Fenwick

ADDRESS: Mtn Grove

V. S. No. 2.

MARGIN RESERVED FOR BINDING

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 HEAL

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... or Village..... or City ..... (NO. ..... St.; ..... Ward)

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

(If death occurre hospital or insti give its NAME i of street and numb

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... (Month) ..... (Day) ..... (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

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

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 Causes (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIEN 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 .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
UNDERTAKER	ADDRESS