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 Harrison

Township ____ or Village ____ or City Gilman City

Registration District No. 338 File No. 1077

Primary Registration District No. 4201 Registered No. ____

(No. ____ St.; ____ Ward)

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

FULL NAME Rose Marie Swint

PERSONAL AND STATISTICAL PARTICULARS

SEX F

COLOR OR RACE Wh

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Infant

DATE OF BIRTH 1 (Month) 2 (Day), 1919 (Year)

AGE ____ yrs. ____ mos. 4 ds.

If LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE (City or town, State or foreign country) Gilman City Mo

PARENTS

NAME OF FATHER W. D. Swint

BIRTHPLACE OF FATHER (City or town, State or foreign country) Davies Co Mo

MAIDEN NAME OF MOTHER Vada Margora Prindle

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Davies Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W D Swint

(ADDRESS) Coffey Mo

Filed 1-6, 1919 Joe Lephaut REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 1 (Month) 6 (Day), 1919 (Year)

I HEREBY CERTIFY, that I attended deceased from 1-4, 1919, to 1-4, 1919, that I last saw her alive on 1-4, 1919 and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Insufficient Nutrition & Lack of Circulation

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

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

(Signed) J A Burlat M. D.

1/6, 1919 (Address) Coffey 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 Coffee Cemetery

DATE OF BURIAL Jan 7, 1918

UNDERTAKER W. D. Haines

ADDRESS Gilman City Mo

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 o
hospital or
give its NA
of street and

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

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

....., 1 .....
(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

.....
(Month) (Day)

I HEREBY CERTIFY, that I attended deceas

....., 191....., to .....

that I last saw h ..... alive on .....

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 Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIE 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

the following diseases, without explanation, as the sole cause of death; Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus.
But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "epidemic cerebrospinal meningitis"); *Diphtheria*