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

1931

1 PLACE OF DEATH

County Jasper

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

Registration District No. 413 File No. .....

Primary Registration District No. 4245 Registered No. 4004

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

2 FULL NAME Francis Clay

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Oct (Month) 14 (Day), 1884 (Year)

7 AGE 34 yrs. 3 mos. 14 ds. If LESS than 1 day, ... hrs. or ..... min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Texas

PARENTS

10 NAME OF FATHER Geo Johnson

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

12 MAIDEN NAME OF MOTHER Lillie Allen

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo Johnson

(Address) Webb City Mo.

15

Filed Feb 10, 1919 J. H. Barson M.D. by H. Barson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan (Month) 28 (Day), 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 20, 1919, to Jan 28, 1919, that I last saw her alive on Jan 28, 1919, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Influenza (Subsequent Pneumonia)

10

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

CONTRIBUTORY (Secondary) .....

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

(Signed) J. H. Barson M. D.

Jan 28, 1919 (Address) Oronogo, Mo.

*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 Oronogo Cem

DATE OF BURIAL Jan 29, 1919

20 UNDERTAKER Webb City Hand Co

ADDRESS Webb City

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

1 PLACE OF DEATH

County ..... DEC 10 1948

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 .....

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

JEFFERSON CITY

GEO. H. JONES, M. D.

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should [illegible] heavenly classified. Exact statements [illegible]