LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County: New Madrid

Township: Anderson — Registration District No.: 55 — File No.: 2 2449

or

Village: — Primary Registration District No.: ~~55~~ 4033 — Registered No.: 60

or

City: Gideon (NO. ..... St.: ..... Ward)

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

2 FULL NAME Fred Kirby

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: July 6 (Month) (Day) 1915 (Year)

7 AGE: 3 yrs. 5 mos. 28 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer): none

9 BIRTHPLACE (City or town, State or foreign country): South Lee Mo

PARENTS

10 NAME OF FATHER: Wm Robert Kirby

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

12 MAIDEN NAME OF MOTHER: Maryan Butram

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): South Lee Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Wm Robert Kirby
(Address): Gideon Mo

15
Filed 1-6, 1919. M. V. Munn, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan 4 (Month) (Day), 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 3, 1919, to Jan 4, 1919, that I last saw h. alive on ....., 1919, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:
10 Membranous Croup
2 hours
Not Given

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

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. Geo W. Cottrill M. D.
1-4, 1919 (Address) Gideon 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: Mount Gilion — DATE OF BURIAL: 1-5, 1919

20 UNDERTAKER: J. C. Gresp — ADDRESS: Gideon Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF
BUREAU OF VITAL STATIST
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)

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

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

..... (Month) (Day)

17 I HEREBY CERTIFY, that I attended dec

....., 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. ..... m

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... m

(Signed) .....

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violen (1) Means of Injury; and (2) whether Accidental, Suicidal

18 LENGTH OF RESIDENCE (For Hospitals, Institutions or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BU

20 UNDERTAKER	ADDRESS

the following diseases, without ... 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.

(If d... hospita... give th... of stre...

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* (avoid use of "Croup"); *Typhoid fever* (never report