

PLACE OF DEATH

County

Township

or

Village

or

City

(No.

CERTIFICATE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

Registration District No.

File No.

Primary Registration District No.

Registered No.

[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
(If write the word)

DATE OF BIRTH

AGE

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)NAME OF
FATHERBIRTHPLACE
OF FATHER
(City or town, State or foreign country)MAIDEN NAME
OF MOTHERBIRTHPLACE
OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

(Month)

(Day)

1919

I HEREBY CERTIFY, that I attended deceased from

Jan 2, 1919, to Jan 6, 1919
that I last saw ~~him~~ alive on Jan 6, 1919

and that death occurred, on the date stated above, at 2-4 p.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

Duration yrs. mos. 5 ds.

Contributory

(SECONDARY)

(Signed)

C. L. Parkhurst, M. D.
Jan 9, 1919 (Address) Houstonia*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

UNDERTAKER

ADDRESS

PLACE OF DEATH

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

County _____

Township _____ or _____ File No. _____

Village _____ or _____ Primary Registration District No. _____ Registered No. _____

City _____ (NO. _____) St. _____ Ward _____

(If death occur hospital or inst give its NAME of street and bur

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
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DATE OF BIRTH	(Month)	(Day)	(Year)
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AGE	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)

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 deceased

, 191, to

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT RECENT RESIDENTS)

At place of death, yrs. mos. ds. 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