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: Stone

Township: Pierce

or

Village:

or

City: (NO. , St., Ward)

Registration District No. 842

Primary Registration District No. 6104

File No. 4387

Registered No.

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

2 FULL NAME Elnora Gipson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Girl

4 COLOR OR RACE: white

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

6 DATE OF BIRTH: Nov (Month) 24 (Day) 918 (Year)

7 AGE: 1 yrs. 1 mos. 13 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): Crane Mo

PARENTS

10 NAME OF FATHER: Emmett Gipson

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Stone Co Mo

12 MAIDEN NAME OF MOTHER: Helen Orton

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Green Co Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Helen Gipson

(Address): Crane Mo

15 Filed 2-3 1919 R W Kelly Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan (Month) 6 (Day) 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Brought to my office dead 191 to 191, that I last saw h alive on 191, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:
Accidentally suffocated.
(This in my opinion)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. L. Kerr M. D.

2-3 1919 (Address) Crane 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: Masonic Cem

DATE OF BURIAL: 1-7 1919

20 UNDERTAKER: W E Hutton

ADDRESS: Crane

LOCAL REGISTRAR'S RECORD — DO NOT PLAN LEAF OUT

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
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)

[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

....., 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

....., 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

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.