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 Chariton

Township or Village Prairie Hill or City (NO. St.; Ward)

Registration District No. 173 File No. 26/19 5110

Primary Registration District No. 4102 Registered No.

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

2 FULL NAME Not named — McDonald

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

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

6 DATE OF BIRTH Jan (Month) 23 (Day) 1919 (Year)

7 AGE ..... yrs. ..... mos. 14 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) Prairie Hill Mo

PARENTS

10 NAME OF FATHER Frank A. McDonald

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

12 MAIDEN NAME OF MOTHER Lela A. Monk

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Rothville Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. A. McDonald

(Address) Prairie Hill

15 Filed Feb 7, 1919 J. D. McAdam Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 2 (Month) 6 (Day) 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 23, 1919, to Feb 6, 1919, that I last saw her alive on Feb 6, 1919, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Inanition — due to premature birth — 7 months Gestation

159
158

(Duration) 151 yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary)

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

(Signed) J. D. McAdam M. D.

Feb 7, 1919 (Address) Prairie Hill

*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 Prairie Hill Cemetery

DATE OF BURIAL Feb 7, 1919

20 UNDERTAKER W. D. Cooper

ADDRESS Prairie Hill

MISSOURI STATE BOARD OF HE

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 occ
hospital or
give its NAM
of street and

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

..... (Month) ..... (Day), 19

17 I HEREBY CERTIFY, that I attended deceas

....., 191....., to ....., 1

that I last saw h..... alive on ....., 1

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 Cau
(1) Means of Injury; and (2) whether Accidental, Suicidal or Hon

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tran
or 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 .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 1
20 UNDERTAKER	ADDRESS