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 Dallas

Township [illegible]

or

Village [illegible]

or

City [illegible] (NO. ..... St. ..... Ward)

Registration District No. 936 File No. 58 5248

Primary Registration District No. 5337 Registered No. 936

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

2 FULL NAME [illegible]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX [illegible]

4 COLOR OR RACE [illegible]

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) [illegible]

6 DATE OF BIRTH [illegible] 7 (Month) (Day) 1919 (Year)

7 AGE ..... yrs. 9 mos. ..... 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) Dallas Co Mo

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) [illegible]

12 MAIDEN NAME OF MOTHER Clara Erksen

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) [illegible] Kansas

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B F Johnson

(Address) Buffalo Mo

15 Filed May 10, 1919 F S White Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 7 (Month) (Day) 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from April 5, 1919, to April 7, 1919, that I last saw her alive on April 7, 1919, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Membranous Crown

10

1648 09

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) [illegible]

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) B F Johnson M. D.

April 9, 1919 (Address) Buffalo 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 Free Will Chapel

DATE OF BURIAL Feb 9, 1919

20 UNDERTAKER Lohmeyer & Co.

ADDRESS Springfield Mo

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 Cato Goodale | **ADDRESS** [illegible]

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.