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.

1 PLACE OF DEATH

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County: North

Township: Green
or
Village:
or
City: ~~Parnell Mo~~ (NO. ..... St.; ..... Ward)

Registration District No. 1057 File No. 8445

Primary Registration District No. 6214 Registered No. 1

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

2 FULL NAME: Dorthea Erdith Flanagan

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: 4 October 3 (Month) 10 (Day) 1914 (Year)

7 AGE: 4 yrs. 3 mos. 28 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): Nodaway Cont Mo

PARENTS

10 NAME OF FATHER: Joseph Flanagan

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Warren Co Iowa

12 MAIDEN NAME OF MOTHER: Olie Wolf

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Missouri

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph Flanagan
(Address) Parnell Mo

15 Filed Feb 14, 1919, T M Cox Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 1 Feb (Month) 8 (Day), 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan. 22, 1919, to Feb 8, 1919, that I last saw her alive on Feb 1, 1919, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows: Bronchial Pneumonia 107A

91

(Duration) ..... yrs. ..... mos. 17 ds.

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

(Signed) Egbert Crowson M. D.
Feb 8, 1919 (Address) Parnell 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: Guilford Mo

DATE OF BURIAL: 2/9, 1919

20 UNDERTAKER: Prof. L. La Fara

ADDRESS: Parnell Mo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state USE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

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

MISSOURI STATE BOARD OF HEALTH