Reagan

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

10622

1 PLACE OF DEATH

County Macon

Township Eagle
or
Village
or
City (NO. , St., Ward)

Registration District No. 533

Primary Registration District No. 5714

File No. ~~10346~~

Registered No. 25

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

2 FULL NAME Iva Lindsey

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

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

6 DATE OF BIRTH Dec 11, 1901 (Month) (Day) (Year)

7 AGE 18 yrs. 3 mos. 6 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) Mackinaw Ill

PARENTS

10 NAME OF FATHER Frank Lindsey

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Ill

12 MAIDEN NAME OF MOTHER Myrtle Shoemaker

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Myrtle Shoemaker Lindsey

(Address) Macon Mo R R

15 Filed 4-10, 1919 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 3/17, 1919 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Mar 10, 1919, to Mar 17, 1919, that I last saw her alive on Mar 17, 1919, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Bronchi)

10

(Duration) ✓ yrs. ✓ mos. 3 ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) ... yrs. ... mos. 7 ds.

(Signed) J. W. Reagan M. D.

Mar 18, 1919 (Address) Macon 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 Bellview Cemetery

DATE OF BURIAL Mar 18, 1919

20 UNDERTAKER Albert Skinner

ADDRESS Macon Mo

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.

LOCAL REGISTRAR'S

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.

WHITE PLAINS, WH