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

12801

1 PLACE OF DEATH

County Vernon

Township Washington or Village ..... or City Nevada Mo (NO. 614, N. Wash. 3039 St. 2 Ward)

Registration District No. 870 File No. .....

Primary Registration District No. ~~6162~~ Registered No. 90.

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

2 FULL NAME Samuel Alexander Earhart

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

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

6 DATE OF BIRTH: Dec. (Month) 5 (Day), 1852 (Year)

7 AGE: 66 yrs. 3 mos. 10 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (City or town, State or foreign country): Texas.

PARENTS

10 NAME OF FATHER: Mitchell Earhart

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

12 MAIDEN NAME OF MOTHER: Candela

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Murray C. Earhart
(Address) 614 N. Wash.

15 Filed 3-24, 1919. T. B. M. Craig Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Mar. 20 (Month) (Day), 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov 5, 1918, to Mar. 20, 1919, that I last saw him alive on Mar 20, 1919, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage from Arteriosclerosis

82A 64 (Duration) ..... yrs. ..... mos. ..... ds.

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

(Signed) L M Brown M. D.
Mar 22, 1919 (Address) Nevada 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: Newton

DATE OF BURIAL: Mar 23, 1917

20 UNDERTAKER: W J Wrenscott

ADDRESS: Nevada, Mo.

Brown

LOCAL REGISTRAR'S REPORT

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

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

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

..... (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**