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: Bee Branch
or
Village:
or
City: (NO. , St.; Ward)

Registration District No. 178 File No. 4 16613

Primary Registration District No. 5246 Registered No. 4

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

2 FULL NAME Irene Annie Schultz

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: May X (Month) 19 (Day), 1919 (Year)

7 AGE: 0 yrs. 6 mos. (3) ds.

If LESS than 1 day, ...hrs. or ....min.?

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

9 BIRTHPLACE (City or town, State or foreign country): Weir Mo

PARENTS

10 NAME OF FATHER: Wm Schultz

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

12 MAIDEN NAME OF MOTHER: Elley B Bixeman

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Chariton Co Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Schultz
(Address) New Cambria

15 Filed May (21) 1919 Mae Sullivan Registrar
Jewess
(Please supply facts in Parenthesis)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May (Month) (22) (Day), 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from May 19, 1919, to X X, 191..., that I last saw her alive on May 19, 1919, and that death occurred, on the date stated above, at (....) m.

The CAUSE OF DEATH* was as follows:

159 Premature Birth

(Duration) 0 yrs. 0 mos. (1) ds.

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

(Signed) J D McAdam M. D.
May (21) 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: Weir Cemetery DATE OF BURIAL: May 23, 1919

20 UNDERTAKER: C. C. Steffes ADDRESS: Weir Mo

V. S. No. 2.

MISSOURI STATE BOARD OF HEALT

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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.

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

MARGIN RESERVED FOR BINDING

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 hospital or institut give its NAME ins of street and numbe

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

....., 191..... (Month) (Day) (Ye

17 I HEREBY CERTIFY, that I attended deceased fr

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

that I last saw h.....alive on ....., 191....

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) .....M.

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

*State the Disease Causing Death, or, in deaths from Violent Causes, s (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicid

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transient or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....d

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