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 Macon

Township ~~Hudson~~ Registration District No. 533 File No. 25490

or

Village Primary Registration District No. 3027 Registered No. 41

or

City Macon (NO. ..... St.: 1st Ward)

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

2 FULL NAME Virginia Rose Carter

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 June 8 (Month) (Day), 1917 (Year)

7 AGE 2 yrs. 2 mos. 20 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) Laplata Mo

PARENTS

10 NAME OF FATHER Leon A Carter

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

12 MAIDEN NAME OF MOTHER Edna McDaniel

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leon A Carter

(Address) Elmer Mo

15 Filed 9-10, 1919 W H Miller Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 28 (Month) (Day), 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Aug 25, 1919, to Aug 28, 1919, that I last saw her alive on Aug 27, 1919, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Entero Colitis

1208 8

105

(Duration) ✓ yrs. ✓ mos. 14 ds.

CONTRIBUTORY (Secondary) none

✓ (Duration) ✓ yrs. ✓ mos. ✓ ds.

(Signed) W H Miller M. D.

Aug 28, 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 Mt Tabor Cemetery

DATE OF BURIAL Aug 28, 1919

20 UNDERTAKER Albert Skinner

ADDRESS Macon 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 .....

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

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