V. S. No. 2.

MARGIN RESERVED FOR BINDING

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

PLACE OF DEATH

...y Lafayette

...ship 0

...e

Registration District No. 465 File No. 7577

Primary Registration District No. 4278 Registered No. 12

Waverly Mo (NO. ..... St.: ..... Ward)

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

FULL NAME Mrs Virginia Smallwood

PERSONAL AND STATISTICAL PARTICULARS

...ale | COLOR OR RACE White | SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widowed

...E OF BIRTH Dec 15, 1841 (Month) (Day) (Year)

78 yrs. 2 mos. 5 ds. If LESS than 1 day, ...hrs. or ...min.?

...UPATION ...rade, profession, or ...cular kind of work Housewife

...eneral nature of industry, ...ness, or establishment in ...h employed (or employer) ——

...HPLACE ...or town, ...or foreign country) Tennessee

NAME OF FATHER Mr Fugua

BIRTHPLACE OF FATHER (City or town, State or foreign country) Tenn.

MAIDEN NAME OF MOTHER Unknown

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Tenn.

ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

...ormant) Mrs James Williams

(ADDRESS) Waverly Mo

...d Mar 8, 1920 G. B. Williamson REGISTRAR

2

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb- 20th, 1920 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 1, 1920, to Feb- 19-, 1920, that I last saw her alive on Feb- 19-, 1920, and that death occurred, on the date stated above, at 2:30 Pm.

The CAUSE OF DEATH* was as follows:

Pneumonia (Hypostatic) following Influenza

11A

111B (Duration) 10 yrs. ..... mos. ..... ds.

Contributory (SECONDARY) ..... (Duration) ..... yrs. ..... mos. ..... ds.

8 (Signed) L F O'Bryant M. D.

March-8, 1920 (Address) Waverly Mo

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

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 .....

PLACE OF BURIAL OR REMOVAL Waverly Mo

DATE OF BURIAL 2-21, 1920

UNDERTAKER T. R. Landrum

ADDRESS Waverly Mo

V. S. No. 2.

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MISSOURI STATE BOARD OF HEA

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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 occur hospital or in give its NAME of street and nu

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., *I*.....
(Month) (Day) (Year)

AGE

.....yrs.....mos.....ds.

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

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

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

MAIDEN NAME OF MOTHER

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191...., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., ...
(Month) (Day)

I HEREBY CERTIFY, that I attended deceased

....., 191...., to....., 1

that I last saw h.....alive on....., 1

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).....

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

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

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENT RECENT RESIDENTS)

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

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 19
UNDERTAKER	ADDRESS