LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County Macon

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

Registration District No. 529 File No. 7773

Primary Registration District No. ~~4315~~ 5705 Registered No.

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

2 FULL NAME Hertha Lee Teter

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE White

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

6 DATE OF BIRTH August (Month) 21 (Day), 1914 (Year)

7 AGE 5 yrs. 6 mos. 22 ds. If LESS than 1 day; ....hrs. or ....min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Moberly Mo.

PARENTS

10 NAME OF FATHER Roy Lee Teter.

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Macon Co. Mo.

12 MAIDEN NAME OF MOTHER Cora Lee Miles

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) Mae Teter
(Address) College Mound Mo.

15 Filed Feb 27, 1920 W. H. Brabson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH February (Month) 12 (Day), 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from 2-11, 1920, to 2-12, 1920, that I last saw her alive on 2-11, 1920, and that death occurred, on the date stated above, at 1a m.

The CAUSE OF DEATH* was as follows:
Malignant Scarletfever
8
(Duration) 01 yrs. mos. 4 hrs

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

(Signed) F. L. Trippeer M. D.
2-12, 1920 (Address) College Mound 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 Moberly Mo. DATE OF BURIAL 2/14, 1920

20 UNDERTAKER Albert Thomas 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 RECORD—DO NOT TEAR LEAF OUT

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

..... (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

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.