CAUSE OF DEATH is 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

County: Pulaski

Township: ~~Liberty~~ or Village: ~~Richland~~ or City: Richland Mo.

Registration District No. 712 — File No. 8562

Primary Registration District No. 4427 — Registered No. 6

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

FULL NAME Harrison Tanner

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
M	W	single

DATE OF BIRTH: 1 (Month) 15 (Day) 1902 (Year)

AGE: 18 yrs. 1 mos. — ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE (City or town, State or foreign country): MO

PARENTS
NAME OF FATHER: James Tanner
BIRTHPLACE OF FATHER (City or town, State or foreign country): MO
MAIDEN NAME OF MOTHER: Celice Harrison
BIRTHPLACE OF MOTHER (City or town, State or foreign country): MO

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. C. Tanner

(ADDRESS) Richland Mo

Filed Feb 16, 1920 Everett A. Oliver REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: 2 (Month) 15 (Day) 1920 (Year)

I HEREBY CERTIFY, that I attended deceased from 2-7, 1920, to 2-13, 1920, that I last saw him alive on 2-13, 1920, and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Flu

11A

109A 10

(Duration) ____ yrs. ____ mos. 2 ds.

Contributory (SECONDARY) Lacunar Pneumonia

(Duration) ____ yrs. ____ mos. 7 ds.

(Signed) Murphy & Hoofer M. D.

Feb 16, 1920 (Address) Richland 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 18 yrs. 1 mos. 0 ds. In the State 18 yrs. 1 mos. 0 ds.

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

Former or usual residence —

PLACE OF BURIAL OR REMOVAL: Richland

DATE OF BURIAL: 2-16, 1920

UNDERTAKER: C. M. Pearcy

ADDRESS: Richland

MISSOURI STATE BOARD OF HEALTH
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 occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____, 1____ (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 _____, 191____ (Month) (Day) (Year)

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.

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	DATE OF BURIAL _____, 191____
UNDERTAKER	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.