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 Stone

Township Grant
or
Village ✓
or
City ✓ (NO. ..... St. ..... Ward)

Registration District No. 1068 File No. 2 11121

Primary Registration District No. 6105 Registered No. 2

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

2 FULL NAME Syble Harris

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: July (Month) 9 (Day) 1905 (Year)

7 AGE: 14 yrs. 7 mos. 1 ds. If LESS than 1 day, ... hrs. or ..... min.?

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

9 BIRTHPLACE (City or town, State or foreign country): Green Co. Mo

PARENTS

10 NAME OF FATHER: B. F. Harris

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

12 MAIDEN NAME OF MOTHER: Mattie Hoffman

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Brown Co Ill.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B. F. Harris
(Address) Marionville Mo.

15 Filed Feb 10 1920 B. F. Smart Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 2 (Month) - 10 (Day), 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Feb-8, 1920, to Feb-10-, 1920, that I last saw her alive on Feb-10-, 1920, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Influenza
11A
11B

10

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary): Pulmonary Hemmorhage
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. L. Kerr M. D.
2-10-, 1920 (Address) Crane 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: Round Tree Cemetery
DATE OF BURIAL: 2-11-, 1920

20 UNDERTAKER: R. H. Fite
ADDRESS: Marionville Mo

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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