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

11178

PLACE OF DEATH

County: Tex

Township: Clinton

or Village: ~~Montana~~

or City ______ (NO. ______ St.; ______ Ward)

Registration District No. 1027 File No. ______

Primary Registration District No. 6136 Registered No. 96

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

FULL NAME Edna May Dawson

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
SEX: female	DATE OF DEATH: Feb 20, 1920 (Month) (Day) (Year)
COLOR OR RACE: white	
SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): single	I HEREBY CERTIFY, that I attended deceased from Feb 12, 1920, to Feb 20, 1920,
DATE OF BIRTH: June 16 — 1903 (Month) (Day) (Year)	that I last saw her alive on Feb 19, 1920,
AGE: 16 yrs. 8 mos. 4 ds. If LESS than 1 day, ___ hrs. or ___ min.?	and that death occurred, on the date stated above, at 7 a m.
OCCUPATION (a) Trade, profession, or particular kind of work: at home	The CAUSE OF DEATH* was as follows: 11A 10B Lobar Pneumonia
(b) General nature of industry, business, or establishment in which employed (or employer): farmg	10 (Duration) ___ yrs. ___ mos. ___ ds.
BIRTHPLACE (City or town, State or foreign country): Boy Co Spencer, Nebraska	Contributory (SECONDARY): Flue
PARENTS — NAME OF FATHER: J M Dawson	8 (Duration) ___ yrs. ___ mos. ___ ds.
BIRTHPLACE OF FATHER (City or town, State or foreign country): Wyoming Ill.	(Signed) H U Daughety M. D.
MAIDEN NAME OF MOTHER: Cary Braithwait	______ 191__ (Address) Mt Grove Mo
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Minnesota	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE	LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.
(Informant) J M Dawson	Where was disease contracted if not at place of death? ______
(ADDRESS) Mountain Grove Mo	Former or usual residence ______
Mar 2 J Dufotherman	PLACE OF BURIAL OR REMOVAL: Brethren Cemetery. DATE OF BURIAL: Feb 21 1920
Filed 2 – 20, 1920 J M Atkinson, for J M Atkinson, REGISTRAR	UNDERTAKER: M L Botten. ADDRESS: Mtn Grove

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

PLACE OF DEATH

County_____

Township _____ or Village_____ or City _____ (NO._____ _____ St._____ Ward)

Registration District No._____ File No._____

Primary Registration District No._____ Registered No._____

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

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

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