LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

...nty Stone

...nship Hurley

...age

Registration District No. 846 File No. 15288

Primary Registration District No. 6283 Registered No. 3

...(NO. ..... St. ..... Ward)

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

2 FULL NAME Isaac Byron Rickman

PERSONAL AND STATISTICAL PARTICULARS

...ale | 4 COLOR OR RACE white | 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

...TE OF BIRTH Sept (Month) 7 (Day) 1918 (Year)

... 1 yrs. 5 mos. 22 ds. If LESS than 1 day, ...hrs. or ....min.?

...CUPATION Trade, profession, or ...icular kind of work None.

General nature of industry ...ness, or establishment in ...ch employed (or employer) —

...THPLACE ...or town, ...or foreign country) Stone Co Mo

10 NAME OF FATHER aff Rickman

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

12 MAIDEN NAME OF MOTHER Ethel Gald

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

...E ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

...formant) Y B Rickman

(Address) Crane R 3

...ed Mch 20 1920 J D Jessup Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar (Month) 1 (Day) 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Feb-22- 1920, to Mar-1- 1920 that I last saw him alive on March-1- 1920, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

11A

167A

10

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

CONTRIBUTORY (Secondary) Influenza

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

(Signed) H. L. Kerr M. D.

3-2- 1920 (Address) Crane

*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 Masonic Cem | DATE OF BURIAL 3 2 1920

20 UNDERTAKER W E Hilton | ADDRESS Crane Mo

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V. S. No. 2. A

MISSOURI STATE BOARD OF HEAL
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 occurr hospital or inst give its NAME of street and nu

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..

17 I HEREBY CERTIFY, that I attended deceased
....., 191....., to ....., 191
that I last saw h.....alive on ....., 191
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 Cause (1) Means of Injury; and (2) whether Accidental, Suicidal or Homi

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans or 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 .....

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