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 import

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

PLACE OF DEATH

nty Shelby

nship Salt Run

age

Registration District No. 830 File No. 23667

Primary Registration District No. 6091 Registered No.

(NO. St.: Ward)

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

FULL NAME Glades M Mavis

PERSONAL AND STATISTICAL PARTICULARS

X male | COLOR OR RACE White | SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) —

TE OF BIRTH June 12 (Month) (Day) 1920 (Year)

E yrs. mos. ds. 2 | If LESS than 1 day, hrs or min.?

CUPATION Trade, profession, or ticular kind of work —

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

THPLACE y or town, e or foreign country) Shelbina Mo

NAME OF FATHER Carl Mavis

BIRTHPLACE OF FATHER (City or town, State or foreign country) Bethel Mo

MAIDEN NAME OF MOTHER Ethel Shaw

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Olney Ill

E ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

formant) Carl Mavis

(ADDRESS) Shelbina Mo

ed June 14 1920 Nettie Clay REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 1 June (Month) 14 (Day) 1920 (Year)

I HEREBY CERTIFY, that I attended deceased from June 12, 1920, to June 14, 1920, that I last saw her alive on June 13, 1920, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia, 7 months,

159 151

(Duration) yrs. mos. ds.

Contributory (SECONDARY) ✓

(Duration) yrs. mos. ds.

(Signed) Chas. M Coppman M.D.

June 14, 1920, (Address) Shelbina 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 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 Shelbina Mo | DATE OF BURIAL June 14 1920

UNDERTAKER Ezra Peter | ADDRESS Shelbina Mo

V. S. No. 2.

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MISSOURI STATE BOARD OF HEAL

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 occurre hospital or insti give its NAME i of street and numb

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

..... (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

..... (Month) ..... (Day) ..... (Y

I HEREBY CERTIFY, that I attended deceased ....., 191..., to ....., 19

that I last saw h..... alive on ....., 19

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) ..... M

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS 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 .....

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