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

County Schuyler

Township or Village or City Queen City (NO. ..... St. ..... Ward)

Registration District No. 806 File No. 28451

Primary Registration District No. 4485 Registered No. 12

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

2 FULL NAME Winnie Blanche Myers

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 January (Month) 27 (Day) 1893 (Year)

7 AGE 27 yrs. ..... mos. 9 ds. If LESS than 1 day, ... hrs. or ..... min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Queen City

PARENTS

10 NAME OF FATHER Ira M Myers

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Missouri

12 MAIDEN NAME OF MOTHER Amand R Shipman

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ira Myers

(Address) Queen City Mo

15 Filed Aug 7, 1920 W H Gieber Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug (Month) 6 (Day), 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from July 20, 1920, to Aug 6, 1920, that I last saw her alive on Aug 6, 1920, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Tuberculosis of lungs

28

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

CONTRIBUTORY (Secondary) .....

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

(Signed) W H Gieber M. D.

Aug 7, 1920 (Address) Queen City

*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 Myers Cem

DATE OF BURIAL Aug 7, 1920

20 UNDERTAKER L. C. Johnson

ADDRESS Queen City Mo

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 .....

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.....

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.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE
MARRIED
WIDOWED
OR DIVORCED
(*Write* the word)

6 DATE OF BIRTH

....., 1.....
(Month) (Day) (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

....., 191.....
(Month) (Day) (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