V. S. No. 2. A

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

County Schuyler

Township

or Village

or City Queen City Mo. (NO. ..... St.; ..... Ward)

Registration District No. 806 File No. 28452

Primary Registration District No. 4485 Registered No. 13

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

2 FULL NAME John Wesley Fletcher

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Married

DATE OF BIRTH Feb (Month) 29 (Day) 1848 (Year)

AGE 72 yrs. 5 mos. 12 ds. If LESS than 1 day, ... hrs. or ..... min.?

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

BIRTHPLACE (City or town, State or foreign country) Missouri

10 NAME OF FATHER Edward Fletcher

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

12 MAIDEN NAME OF MOTHER Elizabeth Griggs

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Paul E Fletcher

(Address) Chicago Ill

Filed Aug 10, 1920 W H Zieber Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug (Month) 10 (Day) 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from June 26, 1920, to Aug 10, 1920, that I last saw him alive on Aug 4, 1920, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

71 Fl 54

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

CONTRIBUTORY (Secondary) About a year

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

(Signed) W H Zieber M. D.

Aug 10, 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 Crowder Cem DATE OF BURIAL Aug 12, 1920

20 UNDERTAKER I. C. Johnson ADDRESS Queen City

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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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 occurred hospital or instit give its NAME in of street and numb

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

....., 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) (Y

17 I HEREBY CERTIFY, that I attended deceased f

....., 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).....M.

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

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transie 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

....., 191.

20 UNDERTAKER

ADDRESS