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

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

PLACE OF DEATH

County: Linn

Township: North Salem Registration District No. 507 File No. 29645-a

or Village: Primary Registration District No. 5672 Registered No. 1

or City: (NO. , St.; Ward)

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

FULL NAME Juanita Pearl McCollum

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Female	white	Single

DATE OF BIRTH: January (Month) 12 (Day), 1917 (Year)

AGE: 3 yrs. 8 mos. 7 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): Winigan Mo

PARENTS
NAME OF FATHER: Tatlow W. McCollum
BIRTHPLACE OF FATHER (City or town, State or foreign country): North Salem Mo
MAIDEN NAME OF MOTHER: Ollie M. Cleeton
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Owasco, Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Tatlow W. McCollum
(ADDRESS) North Salem Mo

Filed Sept 28 1920 T W McCollum REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Sept (Month) 19 (Day), 1920 (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 8, 1920, to Sept 19, 1920, that I last saw her alive on Sept 19, 1920 and that death occurred, on the date stated above, at 3 40 Pm.

The CAUSE OF DEATH* was as follows:

Spinal Meningitis

(Duration) yrs. mos. 12 ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) J. O. Carrico D.O. (Address) North Salem 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	DATE OF BURIAL
North Salem	Sept 21 1920
UNDERTAKER	**ADDRESS**
William G Cram	Winigan Mo

PLACE OF DEATH

County

Township
or
Village
or
City (NO. , St.; Ward)

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

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

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 , 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

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.