LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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: Ozak

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

Registration District No. 647 File No. 29822

Primary Registration District No. 5857 Registered No. 26

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

2 FULL NAME: Earline Sasseen

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: June (Month) 21st (Day) 1917 (Year)

7 AGE: 3 yrs. 2 mos. 18 ds. If LESS than 1 day, ...hrs. or ....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (City or town, State or foreign country): Ozark County Mo

PARENTS

10 NAME OF FATHER: Earl Sasseen

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

12 MAIDEN NAME OF MOTHER: Maud Kirkland

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Earl Sasseen
(Address) Bayou Mo

15 Filed Oct 1st 1920 M. T. Price Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 17 (Day) 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 15, 1920, to Sept 17th, 1920, that I last saw him alive on Sept 16th, 1920, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:
Membranous Croup
10
09
(Duration) ....yrs. ....mos. 4 or 5 ds.

CONTRIBUTORY (Secondary)
8 (Duration) ....yrs. ....mos. ....ds.

(Signed) Lawrence H. Mitchell M. D.
10/10, 1920 (Address) Bakersfield Mo.

*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: Price Cemetery

DATE OF BURIAL: 9-18-, 1920

20 UNDERTAKER: Tom Poe

ADDRESS: Udall Mo

LOCAL 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.....

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

.....(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.....(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