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 sho
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very im

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

PLACE OF DEATH

County Texas

Township Pinery

or

Village ~~Houston~~

or

City ..... (NO. ..... St.; ..... Ward)

Registration District No. 863 File No. 33283-B

Primary Registration District No. 6137 Registered No. 31

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

FULL NAME Allice Smithey Hunter

PERSONAL AND STATISTICAL PARTICULARS

SEX Fremont

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH Sep (Month) 29 (Day), 1919 (Year)

AGE 1 yrs. ..... mos. 12 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) Houston Texas Co Mo

PARENTS

NAME OF FATHER W M Hunter

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

MAIDEN NAME OF MOTHER Hester Coppage

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Texas Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W M Hunter

(ADDRESS) Houston Mo

Filed 10-10, 1920 J R Womack REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 10 (Month) — 9 (Day) —, 1920 (Year)

I HEREBY CERTIFY, that I attended deceased from 9-28-, 1920, to 10-9-, 1920, that I last saw her alive on 10-9-, 1920, and that death occurred, on the date stated above, at 3:10 P.m.

The CAUSE OF DEATH* was as follows:

Erysipelas

150

(Duration) ..... yrs. ..... mos. 12 ds.

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

(Signed) E P Blankinship M. D.

10-10-, 1920 (Address) Houston 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 Centre Baptist

DATE OF BURIAL 10-10, 1920

UNDERTAKER Gaylord V Elliott

ADDRESS Cabool Mo

MISSOURI STATE BOARD OF HEALTH
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 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

....., 1.....
(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

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.