LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

unty Ripley

wnship Harris

lage Acorn

y ..... (NO. ....., ... St.; ..... Ward)

Registration District No. 1008 File No. 37784 c

Primary Registration District No. 3991 Registered No. 6

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

2 FULL NAME Margret Cox

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 SINGLE MARRIED ~~7770~~ WIDOWED OR DIVORCED (Write the word)
rl	White	

TE OF BIRTH Dec 26 (Month) (Day) 1920 (Year)

E ..... yrs. ..... mos. 1 ds. If LESS than 1 day, 9 hrs. or ..... min.?

CUPATION
Trade, profession, or
ticular kind of work .....

General nature of industry
iness, or establishment in
ch employed (or employer) .....

RTHPLACE
y or town,
e or foreign country) Acorn

10 NAME OF FATHER Walter Cox

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

12 MAIDEN NAME OF MOTHER Cetillar Neill

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

IE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

nformant) Lottie Adams

(Address) Acorn

led ....., 191...., ...

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec - 28 - 1920 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Birth, 1920, to Dec 27, 1920, that I last saw her alive on 27 Dec, 1920, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

unknown no Dr

200 A

205 B

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

CONTRIBUTORY (Secondary) .....

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

(Signed) Lottie Adams 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 Cypress Grove

DATE OF BURIAL Dec 28, 1920

20 UNDERTAKER Dan Sipes

ADDRESS Acorn Mo

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V. S. No. 2. A

MISSOURI STATE BOARD OF HEA

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 occu
hospital or in
give its NAME
of street and n

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

....., 19
(Month) (Day)

17 I HEREBY CERTIFY, that I attended decease

....., 191....., to....., 1

that I last saw h.....alive on....., 1

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).....

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

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tra
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
	.....

20 UNDERTAKER	ADDRESS