

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.

PLACE OF DEATH			MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH		
County	<i>Pulaski</i>	Registration District No.	<i>712</i>	File No.	<i>7537</i>
Township	<i>Richland</i>	Primary Registration District No.	<i>4427</i>	Registered No.	<i>5</i>
Village					
City					
FULL NAME			<i>Harlan M. York</i>		
PERSONAL AND STATISTICAL PARTICULARS			2 MEDICAL CERTIFICATE OF DEATH		
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	DATE OF DEATH		
<i>M</i>	<i>W</i>	<i>Widowed</i>	<i>3 5 21</i> (Month) (Day) (Year)		
DATE OF BIRTH			I HEREBY CERTIFY, that I attended deceased from		
<i>3 18 58</i> (Month) (Day) (Year)			<i>no one</i> , 191		
AGE			that I last saw h alive on , 191		
<i>62 yrs. 11 mos. 17 ds.</i>			and that death occurred, on the date stated above, at <i>8 A</i> m.		
OCCUPATION			The CAUSE OF DEATH* was as follows:		
(a) Trade, profession, or particular kind of work			<i>Pulmonary</i>		
(b) General nature of industry, business, or establishment in which employed (or employer)			<i>23A Tuberculosis</i>		
<i>Farming</i>			<i>23B Stomach</i>		
BIRTHPLACE			(Duration) yrs. mos. ds.		
(City or town, State or foreign country)			<i>Unknown</i>		
PARENTS			Contributory (Secondary)		
NAME OF FATHER			(Duration) yrs. mos. ds.		
<i>(married) Mariah York</i>			<i>Unknown</i>		
BIRTHPLACE OF FATHER			(Signed) <i>RE Howell</i> M. D.		
(City or town, State or foreign country)			<i>B-5 1901</i> (Address) <i>Richland</i>		
MAIDEN NAME OF MOTHER			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.		
<i>Martha Mitchel</i>			LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)		
BIRTHPLACE OF MOTHER			At place of death <i>62 yrs. 11 mos. 17 ds.</i> In the State <i>62 yrs. 11 mos. 17 ds.</i>		
(City or town, State or foreign country)			Where was disease contracted if not at place of death? <i>at place of death</i>		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			Former or usual residence		
(Informant) <i>Sam York</i>			PLACE OF BURIAL OR REMOVAL		
(ADDRESS) <i>Richland</i>			DATE OF BURIAL		
Filed <i>Nov 5 1901</i> <i>Evatt A. Oliver</i> REGISTRAR			<i>Mitchel Cemetery</i>		
			UNDERTAKER		
			<i>Chas. Pearcey</i>		
			ADDRESS		
			<i>Richland</i>		

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

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

PLACE OF DEATH

County _____

Township _____

or

Village _____

or

City _____

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

(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	(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)

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.

(Address) _____, 191_____

*State the Disease Causing Death, or, in death 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

UNDERTAKER

ADDRESS