LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

0112

1 PLACE OF DEATH

County: Chariton

Township: Musselfork
or
Village:
or
City: (NO. St.: Ward)

Registration District No. ~~880~~ 860

Primary Registration District No. 5250

File No. 4

Registered No.

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

2 FULL NAME: Harry Elvin Settler

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): —

6 DATE OF BIRTH: Dec (Month) 9 (Day) 1920 (Year)

7 AGE: 0 yrs. 3 mos. 25 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): Musselfork Mo

PARENTS

10 NAME OF FATHER: Benj F. Settler

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

12 MAIDEN NAME OF MOTHER: Blanche Smalley

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): B. F. Settler

(Address): Musselfork Mo

15 Filed: Apr 1921 J E Chrane Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Apr (Month) 4 (Day) 1921 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 4, 1920, to March 6, 1920, that I last saw him alive on 3-6, 1921, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Enteritis

113

(Duration) 0 yrs. 2 mos. 0 ds.

CONTRIBUTORY (Secondary): Intestinal Indigestion

(Duration) yrs. 3 mos. 0 ds.

(Signed) J. D. McAdam M. D.

Apr 4 1921 (Address) Prairie Hill, 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 0 yrs. 3 mos. 0 ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Welcher Cemetery

DATE OF BURIAL: 4-5, 1921

20 UNDERTAKER: Minor undertaking

ADDRESS: Prairie Hill Mo Co. Huntsville

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.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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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.....

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**

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.