LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

19595

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

1. PLACE OF DEATH

County Scott — Registration District No. 820 — File No. 5

Township Sylvania — Primary Registration District No. 6069 — Registered No. 411

City ..... (No. ..... St. ..... Ward)

2. FULL NAME Zella Bell Wall

(a) Residence. No. Oran Mo St., o Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 0 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Infant

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF —

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 22 - 1920

7. AGE

| YEARS | MONTHS | DAYS | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|
| 1 | 4 | 13 | |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer —

9. BIRTHPLACE (CITY OR TOWN) Ash Hill Mo
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Thomas Franklin Wall

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ripley Co Mo

12. MAIDEN NAME OF MOTHER Emma Victoria Carter

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Oxley
(STATE OR COUNTRY) Mo

14. INFORMANT T. F. Wall
(Address)

15. FILED 7-9 1921 G. J. Glickman LJ REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/5 - 1921

17. I HEREBY CERTIFY, That I attended deceased from 7/5 - 1921, 19..., to 7/5, 1921, that I last saw her alive on 7/5, 1921, and that death occurred, on the date stated above, at 6/30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ileo Colitis
9
1,196 113

(duration) ..... yrs. ..... mos. 30 ds.

CONTRIBUTORY (SECONDARY) Pertussis

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Place of death

DID AN OPERATION PRECEDE DEATH? No. DATE OF —

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? —

(Signed) Wm H. Wescoat, M. D

7/6, 1921 (Address) Oran Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Oran Mo — DATE OF BURIAL: 7/6 1921

20. UNDERTAKER: T. S. Heimrer & Co — ADDRESS: Oran Mo

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.

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County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No.....; .....St. .....Ward)

**2. FULL NAME** .....

(a) Residence. No..... St., .....Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) |
|---|---|---|
| | | |

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, .....hrs. or .....min. |
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8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

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9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., 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.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ..... , M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

| 19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19 |
|---|---|
| 20. UNDERTAKER | ADDRESS |

WRITE PLAINLY, WITH UNFADING INK. [illegible]

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.