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 20999

1 PLACE OF DEATH

unty Lawrence
wnship Ozark
r
ilage
r
ty (NO. St. Ward)

Registration District No. 474 File No. 7
Primary Registration District No. 5638 Registered No.

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

2 FULL NAME Woodford Marion Paris.

PERSONAL AND STATISTICAL PARTICULARS

EX ale | 4 COLOR OR RACE White | 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) married

DATE OF BIRTH April (Month) 22 (Day) 1833 (Year)

AGE 88 yrs. 3 mos. 14 ds. | If LESS than 1 day, ...hrs. or ....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry business or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Warren Co. Penn.

10 NAME OF FATHER Solomon C. Paris

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Don't Know

12 MAIDEN NAME OF MOTHER Mary M. [illegible]

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. S. Paris.
(Address) Halltown Mo.

15

Filed 8-6, 1921. A V Clark Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug (Month) 5 (Day), 1921 (Year)

I HEREBY CERTIFY, that I attended deceased from June 22, 1918, to Aug 5, 1921, that I last saw him alive on Aug 2, 1921, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

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

CONTRIBUTORY (Secondary) (Duration) ....yrs. ....mos. ....ds.

(Signed) Leona J. G. Morrison M. D.
8-6, 1921. (Address) Everton 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 ....yrs. ....mos. ....ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Mesenger | DATE OF BURIAL 8-6, 1921.

20 UNDERTAKER Mack Clark | ADDRESS Aurora

V. S. No. 2. A

MARGIN RESERVED FOR BINDING

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

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1. PLACE O
County.....
Township.....
City.....
2. FULL NA
(a) Resid
Length of reside
3. SEX
PER
5A. IF MARRIED HUSBAND (OR) WIFE
6. DATE OF BI
7. AGE
OCCUPATIO
(a) Trade, particular k
(b) Genera business, or which empl
(c) Name o
BIRTHPLAC
(STATE OR
10. NAME
11. BIRTHP
(STAT
12. MAIDEN
13. BIRTHP
(STAT
INFORMANT
(Address)
FILED.....

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 hospital or instit give its NAME in of street and numb

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

....., 191.....
(Month) (Day) (Y

17 I HEREBY CERTIFY, that I attended deceased f
....., 191....., to....., 191...
that I last saw h.....alive on....., 191...
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).....M

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

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transi or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....d

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