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 B

1 PLACE OF DEATH

County Lawrence

Township Ozark — Registration District No. 474 — File No. 16441

or

Village — Primary Registration District No. 5638 — 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 Melvina H. Hasking

PERSONAL AND STATISTICAL PARTICULARS

SEX Female — 4 COLOR OR RACE White — 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) widow

DATE OF BIRTH August (Month) 25 (Day) 1839 (Year)

AGE 83 yrs. 8 mos. 19 ds. — If LESS than 1 day, ...hrs. or ....min.?

OCCUPATION
a) Trade, profession, or particular kind of work None
b) General nature of industry business or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Lawrence Co. Mo

PARENTS

10 NAME OF FATHER Thomas Nickel

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

12 MAIDEN NAME OF MOTHER Jean Hall

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Pearl Downing

(Address) Halltown Mo

Filed 5-15 Th 1923 W Clark Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May (Month) 14 (Day) 1923 (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 1921, to ....., 1923, that I last saw her alive on May 12, 1923, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of the face

(Duration) 9 yrs. 48 mos. ds.

CONTRIBUTORY (Secondary)

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

(Signed) Leona J Morrison M. D.

5-15- 1923 (Address) Halltown 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 Non Cemetery — DATE OF BURIAL 5/15 1923

20 UNDERTAKER Bunk Clark — ADDRESS Halltown

LOCAL REGISTRAR'S RECORD—

V. S. No. 2. ▲

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MISSOURI STATE BOARD OF HEALT
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 occurred i hospital or institut give its NAME inst of street and numbe

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) (Ye

17 I HEREBY CERTIFY, that I attended deceased fr

....., 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 Causes, (1) Means of Injury; and (2) whether Accidental, Suicidal or Homici

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transie 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 ....., 191

20 UNDERTAKER | ADDRESS