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

File No. 19355-C

Registration District No. 607

Primary Registration District No. 4361

Registered No.

PLACE OF DEATH

County: Nodaway

Township: ~~Lincoln~~

or Village: Portaferry

or City: (No. St.: Ward)

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

FULL NAME: Viola May Coleman

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: W

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

DATE OF BIRTH: April 8, 1971 (Month) (Day) (Year)

AGE: 2 yrs. 2 mos. 11 ds. If LESS than 1 day, hrs. or min.?

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

BIRTHPLACE (City or town, State or foreign country): Barkerton Mo

PARENTS
NAME OF FATHER: Oscar Coleman
BIRTHPLACE OF FATHER (City or town, State or foreign country): Mo
MAIDEN NAME OF MOTHER: Edna Ward Coleman
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Nebraska

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Oscar Coleman

(ADDRESS): Portaferry Mo

Filed 10/1, 1923 R K Miller REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: June 19, 1923 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 16, 1923 to June 19, 1923 that I last saw he alive on June 19, 1923 and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Malaria 3d Congestion of lungs (Duration) yrs. mos. 4 ds.

Contributory (Secondary) Malaria (Duration) yrs. mos. ds.

(Signed) H A Lemon M. D.

6-20, 1923 (Address) Portaferry Mo

*State the Disease Causing Death, or, in deaths 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: Portaferry Cemetery

DATE OF BURIAL: June 20, 1923

UNDERTAKER: R D Young

ADDRESS: Portaferry Mo

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

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]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____, 1____
(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)

PARENTS

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.

_____, 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.

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 _____, 191____
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.

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