

RECORD, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PLACE OF DEATH

County Portage
 Township Portage
 or
 Village Portage
 or
 City Portage (NO. _____ St. _____ Ward _____)

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

Registration District No. 607 File No. 11 19356
 Primary Registration District No. 5806 Registered No. _____

FULL NAME Bonnie Marie Alexander

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

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE W SINGLE Single
 MARRIED
 WIDOWED
 OR DIVORCED
 (Write the word)

DATE OF BIRTH July 26, 1923
 (Month) (Day) (Year)

AGE 11 yrs. 1 mos. 1 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) 38
130

BIRTHPLACE (City or town, State or foreign country) Portage

NAME OF FATHER George Alexander

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

MAIDEN NAME OF MOTHER Henrietta Gordon

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. D. Spencer

(ADDRESS) Portage

Filed 7/7 1923 R. H. Miller REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 27, 1923
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 16, 1923 to Jan 27, 1923
 that I last saw her alive on Jan 27, 1923

and that death occurred, on the date stated above, at 41 m.

The CAUSE OF DEATH* was as follows:

Malario
Induratio

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

Contributory (SECONDARY) Malario

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

(Signed) H. D. Spencer M. D.

(Address) Portage

*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 Portageville

DATE OF BURIAL 6/28, 1923

UNDERTAKER W. D. Young

ADDRESS Portageville

Ma

PLACE OF DEATH

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

County _____

Township _____

or _____

Village _____

or _____

City _____

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

(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)
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DATE OF BIRTH _____

(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)

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 _____

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REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____

(Month) _____ (Day) _____ 191 _____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191 _____, to _____, 191 _____, that I last saw him 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) _____

(Address) _____

M. D. _____

* 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. 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 _____

UNDERTAKER _____

ADDRESS _____

191 _____