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

24630

1 PLACE OF DEATH

unty Lawrence

wnship Ozark

r

lage

r

ty (NO. St.; Ward)

Registration District No. 474 File No. 4

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 Edrie Owens.

PERSONAL AND STATISTICAL PARTICULARS

ER	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Single

ATE OF BIRTH

(Month) (Day) 1 (Year)

GE About 17 17 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

CCUPATION
) Trade, profession, or rticular kind of work

) General nature of industry siness or establishment in hich employed (or employer)

IRTHPLACE ity or town, te or foreign country) Lawrence Co. Mo.

10 NAME OF FATHER J. M. Owens

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Green Co. Mo.

12 MAIDEN NAME OF MOTHER Ella Porter

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Lawrence Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. B. Owens

(Address) Halltown Mo.

Filed Aug 4 1922 A V Clark Registrar

Left for Exposition

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug. (Month) 3 (Day) 1922 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov. 11, 1921, to Jan. 1922, that I last saw her alive on July 20, 1922, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the lungs.

(Duration) One yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Leona J. Co. Morrison M. D.

8-3, 1922 (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 Garoutte Cemetery

DATE OF BURIAL 8-4- 1922

20 UNDERTAKER M. J. Clark.

ADDRESS Halltown Mo.

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MISSOURI STATE BOARD OF HEAL
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 occurre
hospital or insti
give its NAME i
of street and num

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
..... (Month) ..... (Day) ....., 1..... (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
..... (Month) ..... (Day) ....., 191... (

17 I HEREBY CERTIFY, that I attended deceased
....., 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 Homic

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transi 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