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. 32432

Registration District No. 101

Primary Registration District No. 5149

Registered No. 6

1 PLACE OF DEATH

County: Caldwell

Township or Village or City: Mirabile

(NO. ..... St.: ..... Ward)

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

2 FULL NAME: H. E. Whitmer

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: Feb. (Month) 25 (Day), 1919 (Year)

7 AGE: 4 yrs. 9 mos. 4 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): Cattis Co Mo.

PARENTS

10 NAME OF FATHER: Harry E. Whitmer

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Caldwell Co Mo

12 MAIDEN NAME OF MOTHER: Bertha Lewis

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Mrs Lewis

(Address): Mirabile Mo.

15

Filed: Dec 12, 1923. J. J. Ballinger, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov. (Month) 29 (Day), 1923 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov-20, 1923, to Nov-29, 1923, that I last saw he alive on Nov-28, 1923, and that death occurred, on the date stated above, at 1 9 m.

The CAUSE OF DEATH* was as follows:

Diphtheria.

(Duration) 10 yrs. ..... mos. 9 ds.

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

(Signed) H. A. Cox M. D.

Dec. 9, 1923 (Address) Mirabile 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: Mirabile Cem

DATE OF BURIAL: Nov. 29, 1923

20 UNDERTAKER: J. J. Ballinger

ADDRESS: Mirabile Mo.

MISSOURI STATE BOARD OF HEALTH
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 in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME.....

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.

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) (Year)

17 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.

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

DATE OF BURIAL
....., 191.....

20 UNDERTAKER

ADDRESS