V. S. No. 2.

RESERVED FO

WRITE PLAINLY, WITH UNFADING INK—THIS IS ANENT 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

PLACE OF DEATH

nty Boone

nship Cedar

age

Registration District No. 76 File No. 6819

Primary Registration District No. 5110B Registered No. 6

(NO. St.: Ward)

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

FULL NAME Bille Fremain

PERSONAL AND STATISTICAL PARTICULARS

X | COLOR OR RACE | SINGLE (MARRIED) WIDOWED OR DIVORCED (Write the word)

ale | white

TE OF BIRTH July 16 (Month) (Day) 1860 (Year)

E 63 yrs. 8 mos. 8 ds. | If LESS than 1 day, hrs. or min.?

CUPATION Trade, profession, or ticular kind of work House wife

General nature of industry, iness, or establishment in ch employed (or employer)

THPLACE y or town, e or foreign country) Missouri

NAME OF FATHER William Sappington

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

MAIDEN NAME OF MOTHER Lucindy Zumalt

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

E ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

formant) Charlie Stollie

(ADDRESS) Hartsburg Mo

ed April 6, 1924 Stella Haynie, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March (Month) 24 (Day), 1924 (Year)

I HEREBY CERTIFY, that I attended deceased from March 1, 1924, to March 24, 1924, that I last saw her alive on the 23 of March, 1924, and that death occurred, on the date stated above, at 220 p.m.

The CAUSE OF DEATH* was as follows:

11A 107A

Fr Pleurisy 11B

(Duration) yrs. mos. 23 ds.

Contributory (SECONDARY) General Broncho

Pneumonia (Duration) yrs. mos. 7 ds.

(Signed) C. P. Megee M. D.

, 191 (Address) Hartsburg

*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 Bonds Chapel | DATE OF BURIAL Mar 25 1924

UNDERTAKER Bass Johnston Mo | ADDRESS Ashland Mo

V. S. No. 2.

ESERVED FOR

WRITE PLAINLY 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 HEA

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____ or Village _____ or City _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurr hospital or inst give its NAME of street and num

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____ (Month) _____ (Day) 1_____ (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 _____ (Month) _____ (Day) 1_____

I HEREBY CERTIFY, that I attended deceased _____, 191____, to _____, 19

that I last saw h____ alive on _____, 19

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 Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS 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 _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 19
UNDERTAKER	ADDRESS