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

PLACE OF DEATH

County: Scott

Township or Village or City: Morley

Registration District No. 819 — File No. 13640

Primary Registration District No. 4495 — Registered No. 10

(NO. ____ St.: ____ Ward)

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

FULL NAME Alpha Taylor

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: W

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

DATE OF BIRTH: May (Month) 8 (Day), 1921 (Year)

AGE: 2 yrs. 10 mos. 23 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): Stoddard Co Mo

PARENTS
NAME OF FATHER: W. R. Taylor
BIRTHPLACE OF FATHER (City or town, State or foreign country): Tennessee
MAIDEN NAME OF MOTHER: Lizzie Williams
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Tennessee

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W R Taylor

(ADDRESS) Morley Mo

Filed 4-3, 1924 Nellie Tomlinson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: April (Month) 1st (Day), 1924 (Year)

I HEREBY CERTIFY, that I attended deceased from March-26, 1924, to April-1st, 1924, that I last saw her alive on March-31, 1924, and that death occurred, on the date stated above, at 3:50 A m.

The CAUSE OF DEATH* was as follows:

Measles

10

7

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) Membranous Croup

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) E. D. Harris M. D.

4-1-1924 (Address) Morley 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: Morley Mo

DATE OF BURIAL: April 1st 1924

UNDERTAKER: [illegible]

ADDRESS: Morley Mo

PLACE OF DEATH

County _____

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

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

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

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

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

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), 191____ (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