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: Gentry

Township: Huggins

or Village:

or City: (NO. ____ St.: ____ Ward)

Registration District No. 309 File No. 7484

Primary Registration District No. 5428 Registered No. 15

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

FULL NAME: Marguerite Ann Haddis

PERSONAL AND STATISTICAL PARTICULARS

SEX: F1 COLOR OR RACE: W. SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: August 19, 1850 (Month) (Day) (Year)

AGE: 74 yrs. 6 mos. 27 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE (City or town, State or foreign country): Clinton Co. Mo

PARENTS
NAME OF FATHER: Andrew Haddis
BIRTHPLACE OF FATHER (City or town, State or foreign country): N. Carolina
MAIDEN NAME OF MOTHER: Elizabeth Buckridge
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Clinton Co. Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): James Haddis

(ADDRESS): Conception Mo

Filed Mar. 22, 1925 W. T. Martin REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Mar. 16, 1925 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mch 14, 1925, to Mch 16, 1925, that I last saw her alive on Mch 16, 1925, and that death occurred, on the date stated above, at 6 P.m.

The CAUSE OF DEATH* was as follows:

Influenza
9280
100

(Duration) ___ yrs. ___ mos. 3 ds.

Contributory (SECONDARY): Mitral Insufficiency

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

(Signed) C. N. Williamson M. D.

Mch 16, 1925 (Address) Gentry 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: Haggensville

DATE OF BURIAL: Mar. 17, 1925

UNDERTAKER: Laton F. Phillips

ADDRESS: Stanberry Mo

MISSOURI STATE BOARD OF HEALTH
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 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)

DATE OF BIRTH _____, 1_____ (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) _____

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 _____, 191____ (Month) (Day) (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

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.