N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. 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 OCCU-

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 17250

1 PLACE OF DEATH

County Adair

Township Morro-W

or

Village

or

City (NO. St.; Ward)

Registration District No. 1039 File No. 6

Primary Registration District No. 5010 Registered No. 6

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

2 FULL NAME William Harvey Daniel

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 ~~SINGLE~~ MARRIED ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word) Married

6 DATE OF BIRTH May 1s (Month) (Day) 1804 (Year)

7 AGE 71 yrs. 1 mos. 6 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer) Farm work

9 BIRTHPLACE (City or town, State or foreign country) Mo

PARENTS

10 NAME OF FATHER Joseph L. Daniel

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) North Carolinia

12 MAIDEN NAME OF MOTHER Clarissa D Patty

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) South Carlinia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. E Daniel

(Address) Green Castle Mo.

15

Filed Aug 9 1925

Clyde Myers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June (Month) 7 (Day) 1925 (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191.... to 5 June, 1925

that I last saw him alive on June 5, 1925

and that death occurred, on the date stated above, at 11 40 p m.

The CAUSE OF DEATH* was as follows:

Locomotor Ataxia

(Duration) 72 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

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

(Signed) T L Taylor M. D.

....., 191.... (Address) Green Castle 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 Daniels Cem.

DATE OF BURIAL 6-9-1925

20 UNDERTAKER G. E. Giles

ADDRESS Green Castle Mo

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or

MISSOURI STATE BOARD OF H
BUREAU OF VITAL STATISTIC
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 dea hospital give its of street

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)

17 I HEREBY CERTIFY, that I attended de
..... 191..., to .....
that I last saw h..... alive on .....
and that death occurred, on the date stated above, at
The CAUSE OF DEATH* was as follows:

.....
.....
..... (Duration) ..... yrs. ..... mo

CONTRIBUTORY (Secondary) .....
..... (Duration) ..... yrs. ..... mo

(Signed) .....
..... 191... (Address) .....

*State the Disease Causing Death, or, in deaths from Violen (1) Means of Injury; and (2) whether Accidental, Suicidal o

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. .....

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL — DATE OF BU

20 UNDERTAKER — ADDRESS

important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaus-