

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

Do not use this space.

820

1. PLACE OF DEATH

County Laclede
Township Center
City Greensfield (No.)

Registration District No. 237
Primary Registration District No. 4144

File No. 52
Registered No.
St. Ward)

2. FULL NAME Myrtle Mae Bounds

(a) Residence. No. St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Willie Bounds

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov-27-

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
37 2 17

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Polk Co. Mo.
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER J. L. Henson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Polk Co. Mo.

12. MAIDEN NAME OF MOTHER Addie Butler

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ross Co. Tenn.

14.

INFORMANT
(Address)

15.

FILED 1-10-29 E. C. Ball
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 8 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 2, 1929, to Jan 8, 1929, that I last saw her alive on Jan 8, 1929, and that death occurred, on the date stated above, at 11:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza

11B (duration) yrs. mos. da. 7

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) Geo. L. Merriam, M. D.
, 19 (Address) Greensfield Mo.

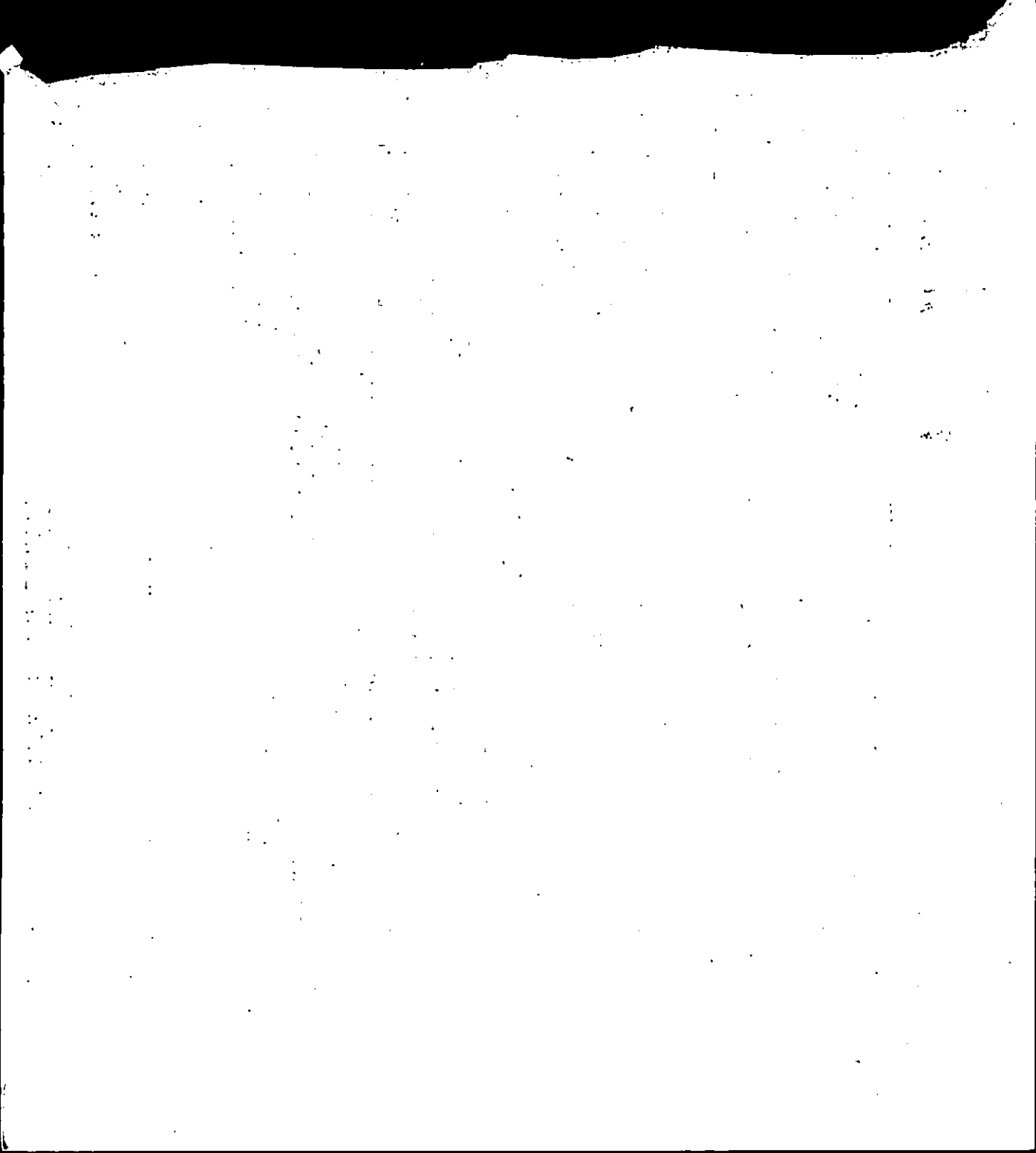
*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Boliver Jan 10 1929

20. UNDERTAKER ADDRESS

Howard Greensfield



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Dade
Township Greenfield
City Greenfield (No.)

Registration District No. 237
Primary Registration District No. 4144

File No. 5-2
Registered No.
St. Ward)

2. FULL NAME

Myrtle Mae Bounds

(a) Residence. No. St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Oct 21 1891

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

37

2

17

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT
(Address)

15.

FILED 915 19 29

Capell

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Jan 8 1929

17.

I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....

that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

REG. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. EXACT STATEMENT OF OCCUPATION is very important. EXACT STATEMENT OF PLACE OF DEATH is very important. EXACT STATEMENT OF CAUSE OF DEATH is very important.

MISSOURI STATE BOARD OF HEALTH

MISSOURI STATE BOARD OF HEALTH

5-820