PLACE OF DEATH

County Adair

Township .... Registration District No. 4 File No. 15163

or Village .... Primary Registration District No. 3001 Registered No. 193

or City Kirksville (No. A. S. O. Hospital St.; 3 Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

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

FULL NAME Dana Hyde Pleak

PERSONAL AND STATISTICAL PARTICULARS	
SEX	Female
COLOR OR RACE	white
SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word)	Married
DATE OF BIRTH	Feb (Month) 2 (Day), 1880 (Year)
AGE	34 yrs. 3 mos. 16 ds. — If LESS than 1 day, ...hrs. or ....min.?
OCCUPATION (a) Trade, profession, or particular kind of work	Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)	
BIRTHPLACE (City or town, State or foreign country)	Moweaqua Ill.
PARENTS — NAME OF FATHER	Ira B. Hyde
BIRTHPLACE OF FATHER (City or town, State or foreign country)	Indiana
MAIDEN NAME OF MOTHER	Savannah [illegible] Butler
BIRTHPLACE OF MOTHER (City or town, State or foreign country)	Indiana

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. S. M. Pleak

(ADDRESS) Tulsa Okla

Filed 5 19 1914 AW [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May (Month) 19 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from May 10, 1914, to May 18, 1914, that I last saw her alive on May 18, 1914, and that death occurred, on the date stated above, at 10 [illegible] m.

The CAUSE OF DEATH* was as follows:

Peritonitis

[illegible]

(Duration) .... yrs. 13 mos. 5 ds.

Contributory (Secondary) Chronic Salpingitis and [illegible]

(Duration) 2 yrs. 4 mos. [illegible] ds.

(Signed) Geo T Still M. D.

May 19 1914 (Address) Kirksville

*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. 8 ds. In the State .... yrs. .... mos. 8 ds.

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

Former or usual residence Tulsa Okla

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moweaqua Ill.	.... 191..
UNDERTAKER	ADDRESS
E. G. Swigert	Kirksville Mo.

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.

PLACE OF DEATH

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

Revised United States Standard Certificate

County.....

Township ..... Registration District No. ..... File No. .....

or

Village..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ..... St.; ..... Ward)

[If death occurre 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) ....., I ..... (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

....., I ..... (Month) ..... (Day) (

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) .....

....., 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 ....., 191
UNDERTAKER	ADDRESS