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

1 PLACE OF DEATH

County Henry

Township ..... Registration District No. 14 File No. 16807

or

Village ..... Primary Registration District No. 4211 Registered No. 16

or

City Windsor (NO. ....., ... St., ... Ward)

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

2 FULL NAME Everette Mack

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M	Black	Single

6 DATE OF BIRTH March (Month) 20 (Day) 1915 (Year)

7 AGE 3 yrs. 2 mos. 4 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry business, or establishment in which employed (or employer) None

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

PARENTS

10 NAME OF FATHER J. T. Mack

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

12 MAIDEN NAME OF MOTHER Amelia Carson

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. T. Mack

(Address) Windsor Mo.

15 Filed May 25 1918 R. J. Jennings Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 24 (Month) (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from May 3, 1918, to May 24, 1918, that I last saw h. alive on May 24, 1918, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows: Bronchial Pneumonia

7
10 TA 91 (Duration) ..... yrs. ..... mos. 21 ds.

CONTRIBUTORY (Secondary) Measles (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Hewalon M. D.

May 25, 1918. (Address) .....

*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	DATE OF BURIAL
Windsor Mo	May 25, 1918

UNDERTAKER	ADDRESS
Chas A Carter	Windsor Mo

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
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 death occurred in a hospital or institution, give its NAME instead of street and number.]

2FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... 1.....
(Month) (Day) (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

....., 191.....
(Month) (Day) (Year)

17 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.

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	DATE OF BURIAL ....., 191.....
20 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD