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

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.

PLACE OF DEATH

County Cooper

Township Pilot Grove or Village or City (No. St.; Ward)

Registration District No. 242 File No. 45237

Primary Registration District No. 5303 Registered No. 23

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

FULL NAME James Lawrence Becker

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: Dec 17, 1918 (Month) (Day) (Year)

AGE: yrs. mos. 2 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): near Pilot Grove Mo

PARENTS

NAME OF FATHER: L. J. Becker

BIRTHPLACE OF FATHER (City or town, State or foreign country): Pilot Grove Mo

MAIDEN NAME OF MOTHER: Nora 4 Woolridge

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Kentucky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. J. Becker

(ADDRESS) Pilot Grove Mo

Filed Dec 26 1918 J. O. Pendleton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Dec 19, 1918 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 17, 1918, to Dec 19, 1918, that I last saw h— alive on Dec 19, 1918, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

157C

Congenital heart lesion

(Duration) mos. 2 ds. 150

Contributory (Secondary) —

(Duration) yrs. mos. ds.

(Signed) W. S. Burgs M. D.

Dec 19 1918 (Address) Pilot Grove 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: St Joseph Cem

DATE OF BURIAL: Dec 20 1918

UNDERTAKER: Elliott & Chapman

ADDRESS: Pilot Grove

PLACE OF DEATH

County.....

Township .....
or
Village.....
or
City .....(NO.....) .....St.;.....Ward)

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

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

.....(Month) .....(Day), *1*.....(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

.....(Month) .....(Day), *191*.....(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**

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

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