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

30267

1 PLACE OF DEATH

County Ray

Township or Village or City Richmond (NO. St.; Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

Registration District No. 777

Primary Registration District No. 3035

File No.

Registered No. 700

2 FULL NAME Lenora May Brady

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

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

6 DATE OF BIRTH Jan (Month) 18 (Day), 1909 (Year)

7 AGE 9 yrs. 6 mos. 27 ds. If LESS than 1 day, ...hrs. or ...min.?

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

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

PARENTS

10 NAME OF FATHER Hiram Brady

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

12 MAIDEN NAME OF MOTHER Flora Bryan

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hiram Brady

(Address) Richmond Mo

15 Filed Sept 16 1918 Geo W Hunt Depty Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 9 (Month) 15 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Aug 26, 1918, to Sept 15, 1918, that I last saw her alive on Sept 15, 1918, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) — yrs. — mos. 20 ds.

CONTRIBUTORY (Secondary)

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

(Signed) C. P. McGaugh, M.D.

9-16, 1918 (Address) Richmond

*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 Sunny Slope

DATE OF BURIAL 9-17, 1918

20 UNDERTAKER Sinnett & Co

ADDRESS Richmond 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.]

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) ....., 1..... (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

..... (Month) ....., 191..... (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.