LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

18483 B

V. S. No. 2.

PLACE OF DEATH
County: Ray
Township: Richmond
Registration District No. 744
Primary Registration District No. 5976 B
File No.
Registered No. 99
City ..... (No. ..... St. ..... Ward)

FULL NAME: Not Named

(a) Residence. No. ..... St., ... Ward. (Usual place of abode) (If nonresident give city or town and State)
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.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

DATE OF BIRTH (MONTH, DAY AND YEAR): June 17 1924

AGE: YEARS 0 | MONTHS 0 | DAYS 0 | If LESS than 1 day, 3 hrs. or ..... min.

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: —

BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ray Co Mo

NAME OF FATHER: Jno E Cox

BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ray Co Mo

MAIDEN NAME OF MOTHER: Gladis M Rise

BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Caldwell Co Mo

INFORMANT: Jno E Cox
(Address): Richmond Mo

FILED Oct 7 1924 R L Hamilton
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): June 18 1924

17. I HEREBY CERTIFY, That I attended deceased from June 17, 1924, 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:
Six & half Months Babies
Lived about 3 Hours

139 1610

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY)

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Home

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) L D Green, M. D.

June 18, 1924 (Address) Richmond Mo

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Hickory Grove Cem
DATE OF BURIAL: 6/18 1924

20. UNDERTAKER: A W Mansur
ADDRESS: Richmond

MARGIN RESERVED FOR BINDING

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.

V. S. No. 2.

MARGIN RESERVED FOR BINDING

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.

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH

County.......... Registration District No.......... File No..........

Township.......... Primary Registration District No.......... Registered No..........

City.......... (No.........., ...St. ....W

2. FULL NAME..........

(a) Residence. No..........St., ...Ward. .... (If nonresident give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or ....min.

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)

PARENTS

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.........., 19.......... ....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1

17. I HEREBY CERTIFY, That I attended deceased from ...., 19.........., to ...., 1

that I last saw h.......... alive on.........., 19.........., a

death occurred, on the date stated above, at..........m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

....

..........(duration)..........yrs. ....mos.

CONTRIBUTORY..........
(SECONDARY)

..........(duration)..........yrs. ....mos.

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)..........

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSE (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICID HOMICIDAL. (See reverse side for additional space.)

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

20. UNDERTAKER | ADDRESS