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

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

PLACE OF DEATH

County Ray

Township Richmond Registration District No. 741 File No. 48146

or Village Hamilton Primary Registration District No. 4443 Registered No. 13

or City ____ (No. ____ St.; ____ Ward)

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

FULL NAME Gertrude Forrester

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Married

DATE OF BIRTH: July (Month) 14 (Day), 1879 (Year)

AGE: 39 yrs. 4 mos. 20 ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE (City or town, State or foreign country): Illinois

PARENTS

NAME OF FATHER: R. W. Plummer

BIRTHPLACE OF FATHER (City or town, State or foreign country): V

MAIDEN NAME OF MOTHER: Pearl Medaugh

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

THE ABOVE IS TRUE TO THE ~~BEST~~ OF MY KNOWLEDGE

(Informant) Ed. Forester

(ADDRESS) Hamilton Mo.

Filed Dec. 4, 1918. G.W. Smith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Dec (Month) 4 (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from ____, 191__, to Dec 4, 1918, that I last saw h[er] alive on Dec 4, 1918, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Influenza

1 1/2

(Duration) 10 yrs. ____ mos. ____ ds.

Contributory (SECONDARY) ____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) G.W. Smith M. D.

Dec 4 1918 (Address) Henrietta

*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
Camden Cemetery	Dec 6, 1918
UNDERTAKER	**ADDRESS**
Stinnett & Co.	Richmond

PLACE OF DEATH

County.....

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

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

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

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

[If death occu
hospital or in
give its NAME
of street and nu

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

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

I HEREBY CERTIFY, that I attended deceased

....., 191....., to....., 1

that I last saw h.....alive on....., 1

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).....M

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, s
(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

MARGIN RESERVED FOR BINDING

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

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