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

38478

PLACE OF DEATH

County Ray

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

Registration District No. 744 File No.

Primary Registration District No. 3976B Registered No. 394

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

FULL NAME Dessie L. Heath

PERSONAL AND STATISTICAL PARTICULARS	
SEX	Female
COLOR OR RACE	White
SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)	Married
DATE OF BIRTH	Jan. 14, 1884 (Month) (Day) (Year)
AGE	31 yrs. 10 mos. 21 ds. If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work	Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)	House keeping
BIRTHPLACE (City or town, State or foreign country)	Ray Co., Mo.
PARENTS: NAME OF FATHER	John W. Hale
BIRTHPLACE OF FATHER (City or town, State or foreign country)	Ray Co, Mo
MAIDEN NAME OF MOTHER	Lucy Rush
BIRTHPLACE OF MOTHER (City or town, State or foreign country)	Va

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Hale

(ADDRESS) Rayville, Mo

Filed Dec 6 1915 Geo W Hunt Depty REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec. 5, 1915 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 3, 1915, to Dec 5, 1915, that I last saw her alive on Dec 5, 1915, and that death occurred, on the date stated above, at 5:05 p.m. The CAUSE OF DEATH* was as follows:

Plastic Bronchitis (?)

131 / 106 / 120

(Duration) — yrs. — mos. 3 ds.

Contributory (SECONDARY) Nephritis Chronic

(Duration) 2 yrs. — mos. — ds.

(Signed) G. A. Lang M. D.

Dec. 6, 1915 (Address) Rayville, 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	DATE OF BURIAL
McGaugh Cem	Dec 6, 1915

UNDERTAKER	ADDRESS
J. E. Broadhurst	Rayville, Mo.

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

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]

FULL NAME ____

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)	DATE OF DEATH ____ (Month) ____ (Day), 191__ (Year)
DATE OF BIRTH ____ (Month) ____ (Day), 1__ (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.
AGE ____ yrs. ____ mos. ____ ds.	If LESS than 1 day, ____ hrs. or ____ min.?		The CAUSE OF DEATH* was as follows: ____ (Duration) ____ yrs. ____ mos. ____ ds.
OCCUPATION (a) Trade, profession, or particular kind of work ____			Contributory (SECONDARY) ____ (Duration) ____ yrs. ____ mos. ____ ds.
(b) General nature of industry, business, or establishment in which employed (or employer) ____			(Signed) ____ M. D.
BIRTHPLACE (City or town, State or foreign country)			____, 191__ (Address) ____
PARENTS: NAME OF FATHER			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
PARENTS: BIRTHPLACE OF FATHER (City or town, State or foreign country)			LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.
PARENTS: MAIDEN NAME OF MOTHER			Where was disease contracted if not at place of death? ____
PARENTS: BIRTHPLACE OF MOTHER (City or town, State or foreign country)			Former or usual residence ____
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) ____ (ADDRESS) ____			PLACE OF BURIAL OR REMOVAL / DATE OF BURIAL ____, 191__
Filed ____, 191__, ____ REGISTRAR			UNDERTAKER / ADDRESS