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

PLACE OF DEATH

County Ray Co Mo

Registration District No. 744 File No. 2191

Township or Village

Primary Registration District No. 3035 Registered No. 217

or City Richmond Mo. (NO. St.; Ward)

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

FULL NAME Marguritt E Hullette

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
SEX: female. COLOR OR RACE: White. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single	DATE OF DEATH: Jan (Month) 8 (Day), 1914 (Year)
DATE OF BIRTH: April (Month) 12 (Day), 1910 (Year)	I HEREBY CERTIFY, that I attended deceased from Dec 26, 1913, to Jan 8, 1914, that I last saw her alive on Jan 7, 1914, and that death occurred, on the date stated above, at midnight m.
AGE: 3 yrs. 8 mos. 26 ds. If LESS than 1 day, hrs. or min.?	The CAUSE OF DEATH* was as follows: Diphtheria 10
OCCUPATION (a) Trade, profession, or particular kind of work: None. (b) General nature of industry, business, or establishment in which employed (or employer): None	(Duration) — yrs. — mos. 11 ds.
BIRTHPLACE (City or town, State or foreign country): Kansas City Mo	Contributory (SECONDARY): none. (Duration) yrs. mos. ds.
PARENTS — NAME OF FATHER: Richard Hullette	(Signed) E. J. McGaugh M. D.
BIRTHPLACE OF FATHER (City or town, State or foreign country): Vernon Co Mo	1-8, 1914 (Address) Richmond
MAIDEN NAME OF MOTHER: Annie Williams	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Randolph Co	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
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Harry Williams (ADDRESS) Richmond Mo	PLACE OF BURIAL OR REMOVAL: City Cemetery. DATE OF BURIAL: Jan 9, 1914
Filed Jan 8, 1914. Geo W Hunt Depty REGISTRAR	UNDERTAKER: Bennett & Co. ADDRESS: Richmond Mo

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.

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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

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 ______