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

41579

PLACE OF DEATH

County Ray

Township Crawford

or

Village

or

City (No. , St.; Ward)

Registration District No. 739

Primary Registration District No. 5974

File No.

Registered No.

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

FULL NAME Mollie Johnson

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Nov (Month) 30 (Day), 1867 (Year)

AGE 51 yrs. 11 mos. 21 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) House Wife

BIRTHPLACE (City or town, State or foreign country) Sheridan Co Mo

PARENTS

NAME OF FATHER Wm Hunt

BIRTHPLACE OF FATHER (City or town, State or foreign country) West Virginia

MAIDEN NAME OF MOTHER Mollie Hunt

BIRTHPLACE OF MOTHER (City or town, State or foreign country) W Va

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter Ackuss

(ADDRESS) Orrick Mo

Filed 11-23, 1918. W. W. Burgess REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov. (Month) 23 (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 23, 1918 to Nov 23, 1918, that I last saw h alive on Nov 23, 1918 and that death occurred, on the date stated above, at 8:40 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

10 d

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) L E Ellis M. D.

Nov 23, 1918 (Address) Orrick, 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 20 yrs. 4 mos. 4 ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death? Camden Mo

Former or usual residence

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
South Point	11-26, 1918
UNDERTAKER	**ADDRESS**
W. W. Burgess	Camden Mo

PLACE OF DEATH

County _____

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

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

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurr hospital or inst give its NAME of street and num

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____ (Month) _____ (Day) _____ (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),

I HEREBY CERTIFY, that I attended deceased

_____, 191____, to _____,

that I last saw h_____ alive on _____,

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) _____

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Cau
(1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSI
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
UNDERTAKER	ADDRESS

DEPARTMENT RECORD