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: Jasper

Township: _____ or Village: _____ or City: Carthage (NO. 6 Central Ave St.; _____ Ward)

Registration District No. 408 — File No. 23187

Primary Registration District No. 3020 — Registered No. 99

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

FULL NAME Guy M. Grigg

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male — COLOR OR RACE: White — SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: Mar. 25 (Month) (Day), 1911 (Year)

AGE: 2 yrs. 4 mos. 1 ds. — If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 0 — 0

BIRTHPLACE (City or town, State or foreign country): Mt Vernon, Mo.

PARENTS
NAME OF FATHER: Guy Grigg
BIRTHPLACE OF FATHER (City or town, State or foreign country): Springfield Mo.
MAIDEN NAME OF MOTHER: Iva Wasten
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Kansas

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Guy Grigg

(ADDRESS) Carthage Mo.

Filed July 27, 1913 W. C. Steele REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: July 26 (Month) (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from July 14, 1913, to July 26, 1913, that I last saw h[illegible] alive on July 26, 1913, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

120 A / 0 / 0

(Duration) ___ yrs. ___ mos. 12 ds.

Contributory (SECONDARY) _____ (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Alvard Wise M. D.

July 27, 1913 (Address) Carthage 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: Carthage Mo.

PLACE OF BURIAL OR REMOVAL: Park Cemetery — DATE OF BURIAL: July 27, 1913

UNDERTAKER: Buell Hud Co. — ADDRESS: Carthage Mo.

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

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

DATE OF BIRTH _____, *1*____ (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 _____, *191*____ (Month) (Day) (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

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 LEGIBLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD