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 ~~Jasper~~ Newton

Township Marion

or Village ~~Diamond~~

or City ~~Carthage~~ (NO. ..... St. ..... Ward)

Registration District No. 613 File No. 5555

Primary Registration District No. 5817 Registered No. 11

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

FULL NAME Greninger Child (Unnamed)

PERSONAL AND STATISTICAL PARTICULARS

SEX: boy

COLOR OR RACE: white

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): single

DATE OF BIRTH: Feb (Month) 23 (Day), 1915 (Year)

AGE: ..... yrs. ..... mos. 2 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): —

BIRTHPLACE (City or town, State or foreign country): Diamond Mo

PARENTS
NAME OF FATHER: Mervin Greninger
BIRTHPLACE OF FATHER (City or town, State or foreign country): Jasper Co. Mo
MAIDEN NAME OF MOTHER: Bertha McKaffee
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Mo Obtainable

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Martha Greninger
(ADDRESS) Carthage Mo

Filed 2-25, 1915 U S Chapman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Feb (Month) 24 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from 2-23, 1915, to 2-24, 1915, that I last saw him alive on 2-23, 1915, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:
Cause of Death Unknown
200 B

184

(Duration) ..... yrs. ..... mos. ..... ds.

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

(Signed) U S Chapman M. D.
2-25, 1915 (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. 2 ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence Diamond Mo

PLACE OF BURIAL OR REMOVAL: Amamulia Cemetery
DATE OF BURIAL: Feb 25, 1915
UNDERTAKER: Knell
ADDRESS: Carthage Mo

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

PLACE OF DEATH

County _____

Township _____ *or*

Village _____ *or*

City _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

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

FULL NAME _____

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.

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**