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

PLACE OF DEATH

County: Henry

Township: _____ or Village: _____ or City: Shudson (NO. _____ St.: _____ Ward)

Registration District No. 14 — File No. 21622

Primary Registration District No. 4211 — Registered No. 20

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

FULL NAME Flora Anna Tull

PERSONAL AND STATISTICAL PARTICULARS

SEX: F — COLOR OR RACE: St — SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: March (Month) 6 (Day), 1891 (Year)

AGE: 24 yrs. 3 mos. 27 ds. — If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): At Home

BIRTHPLACE (City or town, State or foreign country): Henry Co. Mo

PARENTS
NAME OF FATHER: Oliver Evans
BIRTHPLACE OF FATHER (City or town, State or foreign country): Mo
MAIDEN NAME OF MOTHER: Anna L Leslie
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Illinois

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): John S Evans

(ADDRESS): Shudson Mo

Filed July 4, 1915. R J Jennings REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: July (Month) 4 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from June 28, 1915, to July 4, 1915, that I last saw her alive on July 4, 1915, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Bacteriemia

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

Contributory (SECONDARY): Miscarriage

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

(Signed) R J Jennings M. D.

July 4, 1915 (Address) Shudson

*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: Clinton Mo — DATE OF BURIAL: July 5, 1915

UNDERTAKER: W E Huston — ADDRESS: Shudson Mo

...ed, for 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 _____ 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 _____

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**

CAUSE OF DEATH IN DIRECT LINE, TO THE EXTENT TO BE PROPERLY CERTIFIED, BEGINNING WITH DISEASE PRECEDING DEATH AND ENDING WITH DISEASE ACCOUNTING FOR DEATH.