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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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

1 PLACE OF DEATH

County Monroe

Township Marion
or
Village
or
City (NO. St.; Ward)

Registration District No. 379 File No. 15625

Primary Registration District No. 3776 Registered No.

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

2 FULL NAME Chas B. Philpott

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Dec (Month) 25 (Day) 1865 (Year)

7 AGE 51 yrs. 3 mos. 13 ds. If LESS than 1 day, ...hrs. or ....min.?

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

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

PARENTS

10 NAME OF FATHER Chas B. Philpott

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

12 MAIDEN NAME OF MOTHER Anna Wiggington

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) [illegible]

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A B Philpott

(Address) Madison Mo

Filed 4/9 1917 F. A. Thompson Deputy
W. W. Eubank Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr. (Month) 8th (Day) 1917 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Mar. 11th 1917, to Apr. 8th 1917, that I last saw him alive on Apr. 7th 1917, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Aestivo Autumnal Fever.

38 01

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. E. Lensley M. D.

Apr. 9th 1917 (Address) Madison Mo

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

18 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

19 PLACE OF BURIAL OR REMOVAL Madison, Mo. DATE OF BURIAL Apr 10 1917

20 UNDERTAKER Fred A. Thompson ADDRESS Madison, Mo.

LOCAL REGISTRAR'S RE

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association.]

MISSOURI STATE BOARD
BUREAU OF VITAL STA
CERTIFICATE OF DE

1 PLACE OF DEATH

County .....

Township..... Registration District No..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. ...
or
City..... (NO....., ...St.;.....Ward)

2 FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE
MARRIED
WIDOWED
OR DIVORCED
(*Write* the word)

6 DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

7 AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work.....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address).....

15

Filed....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF

16 DATE OF DEATH

.....
(Month)

17 I HEREBY CERTIFY, that I

.....; 191....., to.....

that I last saw h.....alive on.....

and that death occurred, on the date state

The CAUSE OF DEATH* was as follows

.....

.....

.....

..... (Duration).....y

CONTRIBUTORY .....
(Secondary)

..... (Duration).....y

(Signed).....

....., 191..... (Address).....

*State the Disease Causing Death, or, in dea
(1) Means of Injury; and (2) whether Accident

18 LENGTH OF RESIDENCE (For Hospitals or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State..

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL

20 UNDERTAKER

"Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, perioneum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or in-