

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

PLACE OF DEATH

County Monroe
Township Washington
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 582
Primary Registration District No. 5780

File No. 15636
Registered No. 31

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

FULL NAME William Digg

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>Black</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Married</u>
DATE OF BIRTH <u>April 12</u> 19 <u>16</u> (Month) (Day) (Year)		
AGE <u>79</u> yrs. <u>0</u> mos. <u>1</u> ds.		IF LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u>		
(b) General nature of industry, business, or establishment in which employed (or employer) _____		
BIRTHPLACE (City or town, State or foreign country) <u>WA</u>		

PARENTS	NAME OF FATHER <u>WA</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>WA</u>
	MAIDEN NAME OF MOTHER <u>Marric Jones</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>WA</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Summers
(ADDRESS) Clinton mo

Filed Apr 14 1917 J. H. Payer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 13, 1917
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 17, 1916, to April 13, 1917, that I last saw him alive on April 6, 1917.

and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Chemic Poison
(Duration) _____ yrs. _____ mos. 5 ds.

Contributory Prostitution
(SECONDARY) (Duration) 1 yrs. _____ mos. 5 ds.

(Signed) A. P. Ferguson M. D.
April 13, 1917 (Address) Harrison 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 _____

PLACE OF BURIAL OR REMOVAL Clinton mo DATE OF BURIAL April 14, 1917

UNDERTAKER G. W. McClure ADDRESS Harrison mo

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.

PLACE OF DEATH

County _____
Township _____
or Village _____
or City _____ (NO. _____ St. _____ Ward _____)

Registration District No. _____ File No. _____
Primary Registration District No. _____ Registered No. _____

MISSOURI STATE BOARD OF
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Certificate of Death

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

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) _____	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____
I HEREBY CERTIFY, that I attest _____, 191____, to _____ (Month)
that I last saw him _____ alive on _____
and that death occurred, on the date stated _____
The CAUSE OF DEATH* was as follows: _____

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

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) _____

Contributory (SECONDARY) _____ (Duration) _____ yrs.

(Signed) _____ (Duration) _____ yrs.

_____ 191____ (Address) _____

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTES, AND RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs.

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

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DATE _____

UNDERTAKER _____ ADDRESS _____

Filed _____ 191____ REGISTRAR _____

pneumonia ("Pneumonia," unqualified, definite); Tuberculosis of lungs, meninges, peritoneum, 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-

City *Washington*

Registration District No. *582*
Primary Registration District No. *5780*

File No.
Registered No. *31*

(No. St. Ward)

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

FULL NAME *William L. Lipp*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

4 COLOR OR RACE *n* 12
5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *m*

16 DATE OF DEATH *Apr 13 1917*
(Month) (Day) (Year)

6 PLACE OF BIRTH (Month) (Day) (Year)

17 I HEREBY CERTIFY that I attended deceased from 191... to 191... that I last saw him alive on 191... and that death occurred, on the date stated above, at ... m.

7 OCCUPATION (General nature of industry, business, or establishment in which employed (or employer))

The CAUSE OF DEATH* was as follows:
Chronic Intestinal Inflammation

8 PLACE OF BIRTH (City or town, State or foreign country)

CONTRIBUTORY (Secondary) *Institution*
(Duration) yrs. mos. ds.

9 NAME OF FATHER

(Signed) *A. S. Ferguson M. D.*
4/13 1917 (Address) *Flunwell Rd*

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

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

11 MAIDEN NAME OF MOTHER

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

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

Where was disease contracted if not at place of death?
Former or usual residence

13 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant)

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 191...

(Address) *4/14 1917* *A. Payne* Registrar

20 UNDERTAKER ADDRESS

