LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

V. S. No. 2.

MARGIN RESERVED FOR BINDING

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.

1 PLACE OF DEATH

County: Pike

Township: ~~Ashley~~ or

Village: or

City: Ashley (NO. ..... St.: ..... Ward)

Registration District No. 643 File No.

Primary Registration District No. 4407 Registered No. 35997

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

2 FULL NAME Bill Woods

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED or DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: unknown (Month) (Day) 1 (Year)

7 AGE: Aged 78 yrs. ..... mos. ..... ds.

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

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

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

PARENTS

10 NAME OF FATHER: unknown

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

12 MAIDEN NAME OF MOTHER: unknown

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. G. Michie
(Address) Ashley Mo

15
Filed Nov 26 1917 J. E. Rees Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct 22 (Month) (Day), 1917 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 1, 1917, to 10-22, 1917, that I last saw h. alive on Oct 20, 1917, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows: Tuberculosis – Pthysis Pulmy 23 Hg

(Duration) 2 yrs. – mos. – ds.

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

(Signed) J. H. Hartsfield M. D.
10/23, 1917 (Address) Bowling Green

*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. 8 ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence: Pike County

19 PLACE OF BURIAL OR REMOVAL: Ashley

DATE OF BURIAL: Oct 27, 1917

20 UNDERTAKER: Tinsley & Barthard

ADDRESS: B. Green Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

1 PLACE OF DEATH

County .....

Township ..... or

Village ..... or

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

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

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No .....

[If death occurr hospital or instit give its NAME i of street and nun

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

..... (Month) ..... (Day), 1..... (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 DEATH

16 DATE OF DEATH

..... (Month) ..... (Day), 191... (

17 I HEREBY CERTIFY, that I attended deceased

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

that I last saw h.....alive on ....., 191

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

The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

CONTRIBUTORY .....
(Secondary)

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

(Signed) ..... M.

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

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transi or Recent Residents)

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

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

Former of usual residence .....

19 PLACE OF BURIAL OR REMOVAL | **DATE OF BURIAL** ....., 19

20 UNDERTAKER | **ADDRESS**

Revised United States Standard

"Typhoid pneumonia"); *Lobar pneumonia; Broncho-*