40487-2

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

Received

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

B

1 PLACE OF DEATH

County Berry Co.

Township Liberty

Village ~~Exeter~~

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

Registration District No. 24 File No. 40487-2

Primary Registration District No. 3050 Registered No. 12

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

2 FULL NAME Ruth Paris

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Girl

4 COLOR OR RACE White

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

6 DATE OF BIRTH March (Month) 21 (Day) 1913 (Year)

7 AGE 4 yrs. 9 mos. ..... ds.

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

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

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

10 NAME OF FATHER J. A. Paris

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Green Co. Mo.

12 MAIDEN NAME OF MOTHER Maud Naught

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Berry Co. Mo.

I HEREBY CERTIFY THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. A. Paris

(Address) Exeter Mo.

[illegible] 1/28 1917 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 12 (Month) 10 (Day) 1917 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Dec 10, 1917, to Dec 11, 1917, that I last saw her alive on Dec 11, 1917, and that death occurred, on the date stated above, at 2 P.m.

The CAUSE OF DEATH* was as follows:

16 Infantile Paralysis

63

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

CONTRIBUTORY (Secondary) .....

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

(Signed) D. N. Dabbs M. D.

....., 191.... (Address) Rocky Comfort 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 Munse Chappell

DATE OF BURIAL Dec. 13, 1917

20 UNDERTAKER E. F. Sayles

ADDRESS Rocky Comfort

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County .....

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

[If death occurred in hospital or give its NAME of street and

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..... (Year)

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 ..... 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.

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	DATE OF BURIAL

20 UNDERTAKER	ADDRESS