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.

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

1 PLACE OF DEATH

County Greene

Township ..... Registration District No. 318 File No. 32873

or

Village ..... Primary Registration District No. 2001 Registered No. 700

or

City Springfield Mo (NO. 1520 E Florida St.; ..... Ward)

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

2 FULL NAME Infand Dau. Mr & Mrs John W Edwards

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Infant

6 DATE OF BIRTH: Oct (Month) 11 (Day), 1918 (Year)

7 AGE: ..... yrs. ..... mos. 4 ds.

If LESS than 1 day, 4 hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry business, or establishment in which employed (or employer): 1798

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

PARENTS

10 NAME OF FATHER: John W Edwards

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

12 MAIDEN NAME OF MOTHER: Verna Bingman

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John W Edwards

(Address) 1520 East Florida

15 Filed OCT 16 1918, 191 Edwin F James Registrar

Dallie B Johnson Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct 16 (Month) ..... (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from 7 PM Oct 15, 1918, to 4 AM Oct 16, 1918, that I last saw her alive on Oct 16, 1918, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Accidental administration of 1/4 gr Morphine sulph.

165 (Duration) ..... yrs. ..... mos. 14 hours ds.

CONTRIBUTORY (Secondary) Infant 4 days old

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

(Signed) W M F Brown M. D.

Oct 16, 1918 (Address) Springfield 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: Mount Pisga Cem

DATE OF BURIAL: Oct 17, 1918

20 UNDERTAKER: F W Klingner & Co 424

ADDRESS: E Cont St

MISSOURI STATE BOARD OF HEALTH
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 a hospital or institution, give its NAME instead of street and number.]

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 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.

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 ....., 191.....

20 UNDERTAKER

ADDRESS

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.

WRITE PLAINLY, WITH INFADING INK—THIS IS A PERMANENT RECORD