Hamidley

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

1 PLACE OF DEATH

County Prairie

Township ..... Registration District No. 318 File No. 32920

or

Village ..... Primary Registration District No. 2001 Registered No. 762

or

City Springfield Mo (NO. Red Cross Hospital St. Ward)

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

2 FULL NAME Mrs Mary E Gladwell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: Oct. 6 (Month) (Day), 1846 (Year)

7 AGE: 22 yrs. ..... mos. 17 ds.

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

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

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

PARENTS

10 NAME OF FATHER: E B Gladwell

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

12 MAIDEN NAME OF MOTHER: Cora Hall

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. B. Gladwell

(Address) R. F. D. #2

15 Filed OCT 25 1918, 191.. Edwin F. James Registrar
Dallie B Johnson Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct. 23 (Month) (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct. 22, 1918, to Oct. 22, 1918, that I last saw her alive on Oct. 23, 1918, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

11 A Influenza

107 A 10

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary): Broncho Pneumonia

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

(Signed) W E Handley M. D.

10/24, 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: Hazelwood

DATE OF BURIAL: 10/23, 1918

20 UNDERTAKER: Bentz Hurtles

ADDRESS: Walnut & Market

MISSOURI STATE BOARD OF H
BUREAU OF VITAL STATISTIC
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 hospital give its N of street a

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) 1

17 I HEREBY CERTIFY, that I attended deces
....., 191....., to .....
that I last saw h.....alive on .....
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) .....
....., 191..... (Address) .....

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tr 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 or usual residence .....

19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL

20 UNDERTAKER | ADDRESS