Hom

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 or Village or City Springfield, Mo. (NO. St Johns Hospital St.; Ward)

Registration District No. 318 File No. 32933

Primary Registration District No. 2001 Registered No. 777

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

2 FULL NAME E. Maude Peck

**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 April (Month) 15 (Day) 1891 (Year)

7 AGE 27 yrs. 6 mos. 11 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 Isaac Moore

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

12 MAIDEN NAME OF MOTHER Millie Kilburne

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James D. Peck

(Address) Springfield, Mo.

15 Filed OCT 26 1918 191 Edwin F. James Registrar

Dallie B Johnson Deputy Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH Oct (Month) 26th (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from 10 14, 1918, to 10 26, 1918, that I last saw her alive on Oct 26, 1918, and that death occurred, on the date stated above, at 12 45 P m.

The CAUSE OF DEATH* was as follows:

Influenza

11 B 10

(Duration) ....yrs. ....mos. 13 ds.

CONTRIBUTORY (Secondary)

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

(Signed) W R Harman M. D.

10 26, 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 Mathis Cemetery

DATE OF BURIAL 10-27, 1918

20 UNDERTAKER Paxson Und Co.

ADDRESS 410 South 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 |

**WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD**

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