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

**PLACE OF DEATH**

County Pall

Township ____ or Village ____ or City New London (NO. ____ St.; ____ Ward)

Registration District No. 724 File No. 35315

Primary Registration District No. 4432 Registered No. 5-2

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

FULL NAME Nellie Epperson

**PERSONAL AND STATISTICAL PARTICULARS**

SEX: female

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: June (Month) 24 (Day), 1916 (Year)

AGE: 2 yrs. ____ mos. ____ ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

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

PARENTS
NAME OF FATHER: Geo Epperson
BIRTHPLACE OF FATHER (City or town, State or foreign country): Mo
MAIDEN NAME OF MOTHER: Lizzie Anderson
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo Epperson

(ADDRESS) New London Mo.

Filed 12-1- 1918. T. J. Downing REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH: Oct (Month) 22 (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 11, 1918, to Oct 22, 1918, that I last saw her alive on Oct 22, 1918, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Influenza

11 A

10 Hrs

10

(Duration) ____ yrs. ____ mos. 11 ds.

Contributory (SECONDARY) Pneumonia

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

(Signed) J Rogers M. D.

8 Oct 1918 (Address) New London

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

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 ____

PLACE OF BURIAL OR REMOVAL: Barclay

DATE OF BURIAL: 10/23, 1918

UNDERTAKER: Hue Pepper

ADDRESS: New London Mo

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 import

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

**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]

**FULL NAME**.....

**PERSONAL AND STATISTICAL PARTICULARS**

| SEX | COLOR OR RACE | SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word) |
|---|---|---|
| | | |

DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

AGE

.....yrs.....mos.....ds.

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

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

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

MAIDEN NAME OF MOTHER

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191....., .....
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH

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

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.

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.....

| PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL |
|---|---|
| | ....., 191..... |
| UNDERTAKER | ADDRESS |