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 40719

1 PLACE OF DEATH

County Livingston

Township Jackson or Village or City (NO. St. Ward)

Registration District No. 962 File No.

Primary Registration District No. 5675 Registered No. 18

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

2 FULL NAME Sova Nothnagle

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE No

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

6 DATE OF BIRTH April (Month) (Day) 1888 (Year)

7 AGE 30 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

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

(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 Manda Hopper

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

12 MAIDEN NAME OF MOTHER Wm Nothnagle

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Nothnagle

(Address) Chillicothe

15 Filed Nov 26 1918 W. L. White Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 11 (Month) 22 (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov 14, 1918, to Nov 22, 1918, that I last saw him alive on Nov 22, 1918, and that death occurred, on the date stated above, at 12 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia following Influenza

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm L. White M. D.

11-23, 1918 (Address) Chillicothe 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 Mt Pleasant

DATE OF BURIAL 11-24, 1918

20 UNDERTAKER Morris

ADDRESS Chillicothe Mo

# OURI 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) ....., 1..... (Day) (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) ....., 191..... (Day) (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.