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 .....

Township ..... or Village ..... or City ..... (NO. 3832 Folsom Av. St.; 13 Ward)

Registration District No. 791 File No. 43067 12020

Primary Registration District No. 1003 Registered No. ---

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

2 FULL NAME John Wilbert Pickett

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

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

6 DATE OF BIRTH Sept (Month) 17 (Day) 1887 (Year)

7 AGE 31 yrs. 3 mos. 7 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work U. S. Postoffice.
(b) General nature of industry business, or establishment in which employed (or employer) Government Clerk

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

PARENTS

10 NAME OF FATHER James S. Pickett

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

12 MAIDEN NAME OF MOTHER Valoria Taylor.

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 S. Pickett
(Address) 3832 Folsom Av

15 Filed 1 27 1918, 191 Mary C. Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov (Month) 24 (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov 18, 1918, to Nov 24, 1918, that I last saw him alive on Nov 24, 1918, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Broncho
11 P
10 P
10

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

CONTRIBUTORY (Secondary) Influenza

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

(Signed) H. C. Owen M. D.

11/25, 1918 (Address) 3833 Folsom

*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 Shelbina, Mo. DATE OF BURIAL Nov 27, 1918

20 UNDERTAKER Pertz Bros 2739 Lafayette ADDRESS

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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