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 sta
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very importan

DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County Washington

Township Richwoods
or
Village
or
City (NO. St.; Ward)

Registration District No. 889 File No. 4558

Primary Registration District No. 6185 Registered No. 2

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

2 FULL NAME James Alfred Dockery.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

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

6 DATE OF BIRTH: July (Month) 26 (Day) 1882 (Year)

7 AGE: 36 yrs. 5 mos. 21 ds. If LESS than 1 day, ...hrs. or ....min.?

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

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

PARENTS

10 NAME OF FATHER: James Dockery

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

12 MAIDEN NAME OF MOTHER: Bridget Kelly

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Anna Dockery
(Address) Richwoods

15 Filed Jan 18, 1919 David Ford M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan. (Month) 17 (Day) 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 8, 1919, to Jan 17, 1919 that I last saw him alive on Jan 16, 1918 and that death occurred, on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
114
108 (Duration) yrs. 10 mos. 5 ds.

CONTRIBUTORY (Secondary) Influenza
(Duration) yrs. mos. 9 ds.

(Signed) David Ford M. D.
Jan 18, 1919 (Address) Richwoods 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: Calvary Cemetery St Louis Mo
DATE OF BURIAL: Jan 20, 1919

20 UNDERTAKER: Bird
ADDRESS: Festus Mo

LOCAL REGISTRAR'S RECORD—DO NOT

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 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
....., 191.... (Month) (Day) (Ye

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

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transie 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 ....., 19
20 UNDERTAKER	ADDRESS

for malignant neoplasms); *Measles; Whooping-cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, [illegible] "Anemia" [illegible]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespec-

WRITE WITH INDELIBLE INK—THIS IS A PERMANENT RECORD