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

1 PLACE OF DEATH

County: Perry

Township or Village or City: Bois Brule / Belgique

Registration District No. 1128 File No. 23 6802

Primary Registration District No. 5879-A Registered No.

(NO. ..... St.; ..... Ward)

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

2 FULL NAME: Hazel M. Watts

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: July (Month) 23 (Day) 1912 (Year)

7 AGE: 6 yrs. 7 mos. 4 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): Frederick town Mo.

PARENTS

10 NAME OF FATHER: Roy W. Watts

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

12 MAIDEN NAME OF MOTHER: Meary A. Byers

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roy W. Watts

(Address) Belgique Mo.

15 Filed Feb 27 1919 Frank H. Westmon By Alois Staelens Sub Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb (Month) 27 (Day) 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Feb 18, 1919, to Feb. 27, 1919 that I last saw her alive on Feb 27, 1919 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows: Scarlet Fever

8

07

(Duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary)

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

(Signed) J. A. Brown M. D.

Feb 28, 1919 (Address) Belgique 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: Belgique Mo.

DATE OF BURIAL: Feb. 28, 1919

20 UNDERTAKER: Alois Staelens

ADDRESS: Belgique Mo.

MISSOURI STATE BOARD OF HEAL
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 occurr hospital or insti give its NAME i of street and nu

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.

17 I HEREBY CERTIFY, that I attended deceased

..... 191..... to ....., 19

that I last saw h.....alive on ....., 19

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) .....

....., 191..... (Address) .....

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tran 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
	....., 1
20 UNDERTAKER	**ADDRESS**