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 Jasper

Township Mineral
or
Village
or
City (NO. , St.; Ward)

Registration District No. 413 File No. 10310 ~~10034~~

Primary Registration District No. 5559 Registered No. 5010

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

FULL NAME Frank Howard

PERSONAL AND STATISTICAL PARTICULARS

SEX Male

COLOR OR RACE white

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

DATE OF BIRTH May (Month) 13 (Day), 1904 (Year)

AGE 14 yrs. 9 mos. 26 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country) Missouri

PARENTS

NAME OF FATHER L. G. Howard

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

MAIDEN NAME OF MOTHER Hattie Wruk

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lewis G. Howard

Rt (ADDRESS) Oronogo Mo

Filed Apr. 10 1919. J. S. Barson M.D. by H. Barson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March (Month) 9 (Day), 1919 (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 5, 1919, to Mar 9, 1919, that I last saw him alive on Mar 9, 1919, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

10 Influenza followed by (Subsequent Pneumonia)

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

Contributory (SECONDARY)

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

(Signed) James J. O'Brien M. D.

Mar 1919 (Address) Webb City Mo.

*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 Howard Cemetery

DATE OF BURIAL Mar 10 1919

UNDERTAKER Rouey Merc Co

ADDRESS Carl Jct Mo.

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

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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