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.

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

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

PLACE OF DEATH

County Moniteau

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

Registration District No. 574

File No. 2306

Primary Registration District No. 5772

Registered No. 2

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

FULL NAME Stillborn

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word):

DATE OF BIRTH: Jan (Month) 30 (Day), 1910 (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): Moniteau Co. Mo

PARENTS

NAME OF FATHER: John Heinrich

BIRTHPLACE OF FATHER (City or town, State or foreign country): Moniteau Co mo

MAIDEN NAME OF MOTHER: Bertha Wahle

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Moniteau Co mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S M Tool

(ADDRESS) Prairie Home Mo

Filed Feb. 12 1910 W. J. Dearing REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Jan 30th (Month) (Day), 1910 (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: Stillborn

No Cord

(Duration) yrs. mos. ds.

Contributory (SECONDARY) Unknown

(Duration) yrs. mos. ds.

(Signed) S M Tool M. D.

Feb 12, 1910 (Address) Prairie Home 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: Moniteau Church

DATE OF BURIAL: Jan 31st 1910

UNDERTAKER: Had none

ADDRESS

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 ____________

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	MEDICAL CERTIFICATE OF DEATH
SEX / COLOR OR RACE / SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word)	DATE OF DEATH ____________ (Month) (Day), 191__ (Year)
DATE OF BIRTH ____________ (Month) ______ (Day), 1____ (Year)	I HEREBY CERTIFY, that I attended deceased from ____________, 191____, to ____________, 191____,
AGE ______ yrs. ______ mos. ______ ds. If LESS than 1 day, ____ hrs. or ____ min.?	that I last saw h____ alive on ____________, 191____, and that death occurred, on the date stated above, at ______ m.
OCCUPATION (a) Trade, profession, or particular kind of work ____________	The CAUSE OF DEATH* was as follows:
(b) General nature of industry, business, or establishment in which employed (or employer) ____________	
BIRTHPLACE (City or town, State or foreign country)	____________ (Duration) ______ yrs. ______ mos. ______ ds.
PARENTS — NAME OF FATHER	Contributory (SECONDARY) ____________
PARENTS — BIRTHPLACE OF FATHER (City or town, State or foreign country)	____________ (Duration) ______ yrs. ______ mos. ______ ds.
PARENTS — MAIDEN NAME OF MOTHER	(Signed) ____________ M. D.
PARENTS — BIRTHPLACE OF MOTHER (City or town, State or foreign country)	____________, 191____ (Address) ____________
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
(Informant) ____________	LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.
(ADDRESS) ____________	Where was disease contracted if not at place of death? ____________
	Former or usual residence ____________
Filed ____________, 191____, ____________ REGISTRAR	PLACE OF BURIAL OR REMOVAL / DATE OF BURIAL ____________, 191____
	UNDERTAKER / ADDRESS