

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

PLACE OF DEATH

County Moniteau
Township Willow Fork
or
Village _____
or
City _____ (NO. _____)

Registration District No. 573
Primary Registration District No. ~~499~~
5771a

File No. 6111

Registered No. 3

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

FULL NAME Ollie May Hess

PERSONAL AND STATISTICAL PARTICULARS

SEX female COLOR OR RACE white
SINGLE MARRIED WIDOWED OR DIVORCED married
(Write the word)

DATE OF BIRTH May 9, 1874
(Month) (Day) (Year)

AGE 37 yrs. 9 mos. 12 ds.
If LESS than 1 day, hrs. or min.?

OCCUPATION (a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 9-110

BIRTHPLACE (City or town, State or foreign country) Cooper Co. Mo

PARENTS
NAME OF FATHER John Barstetter
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio
MAIDEN NAME OF MOTHER Fulber
BIRTHPLACE OF MOTHER (City or town, State or foreign country) don't know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. L. Hess

(ADDRESS) Fortuna Mo

Filed Feb 22, 1913
A. L. B. Nelson
Frank Wilson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb. 21, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 17, 1913, to Feb 21, 1913, that I last saw him alive on Feb 21, 1913, and that death occurred, on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonitis (non purpurial)
(Cause not known)

109 (Duration) yrs. mos. 4 ds.
Contributory (SECONDARY) (Duration) yrs. mos. ds.
(Signed) Frank Williams M. D.
Feb 22, 1913 (Address) Tipton, 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 Clarksburg, Mo
DATE OF BURIAL Feb. 23, 1913
UNDERTAKER L. Patterson & Son
ADDRESS Tipton, Mo

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.

PLACE OF DEATH

County _____

Township _____
or _____

Village _____

or _____

City _____ (NO. _____)

Registration District No. _____

Primary Registration District No. _____

File No. _____

Registered No. _____

St. _____ Ward) _____
(If hospital give of str

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____ COLOR OR RACE _____ SINGLE
MARRIED
WIDOWED
OR DIVORCED
(If this the word)DATE OF BIRTH _____ (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)

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

MISSOURI STATE BOARD OF
BUREAU OF VITAL STATIS'
CERTIFICATE OF DEATHRevised United States Standard Certificate
of Death

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____

I HEREBY CERTIFY, that I attended (

_____ 191____, to _____
that I last saw h_____ alive on _____

and that death occurred, on the date stated above

The CAUSE OF DEATH* was as follows:

(Duration) _____ yrs. _____ m

Contributory

(SECONDARY)

(Duration) _____ yrs. _____ m

(Signed) _____

191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Viol
(1) Death of Injury and (2) whether Accidental, Suicidal, or Homicidal
LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS,
RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs.

Whereas was disease contracted if not at place of death?

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF _____

UNDERTAKER _____ ADDRESS _____