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 Moniteau

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

Registration District No. 1095

Primary Registration District No. 5770

File No. 34841

Registered No. ~~12~~ 18

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

FULL NAME Died Unnamed

PERSONAL AND STATISTICAL PARTICULARS

SEX: M

COLOR OR RACE: W

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

DATE OF BIRTH: Oct 17, 1918 (Month) (Day) (Year)

AGE: 0 yrs. 0 mos. 1 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION (a) Trade, profession, or particular kind of work: Infant

(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: Chas. Jas Ehrlinger

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

MAIDEN NAME OF MOTHER: Henrietta Schmidt

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. J. Ehrlinger

(ADDRESS) Clarksburg, Mo.

Filed Oct 18, 1918, H C Freudenberger REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct 18, 1918 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 17, 1918, to Oct 18, 1918, that I last saw him alive on Oct 17, 1918, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

159

151

(Duration) yrs. mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) H C Freudenberger M. D.

Oct 18, 1918 (Address) Clarksburg, 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: St. Andrews Cem. Tipton, Mo.

DATE OF BURIAL: Oct 19, 1918

UNDERTAKER: [illegible] Kopp

ADDRESS: Tipton Mo

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		
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)
DATE OF BIRTH ______ (Month) ______ (Day), 1______ (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 ______ (Month) ______ (Day), 191____ (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