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

V. S. No. 2.

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

MARGIN RESERVED FOR BINDING

PLACE OF DEATH

County Ray Co. Mo.

Township ____ or Village ____ or City Richmond Mo (No. ____ St.: ____ Ward)

Registration District No. 1st — File No. 37195

Primary Registration District No. 3035 — Registered No. 208

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

FULL NAME Raymond D Gardner

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

DATE OF BIRTH Sept 27 (Month) (Day), 1903 (Year)

AGE 10 yrs. 2 mos. 3 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

BIRTHPLACE (City or town, State or foreign country) Marceline Mo

NAME OF FATHER Raymon Gardner

BIRTHPLACE OF FATHER (City or town, State or foreign country) Linn City mo

MAIDEN NAME OF MOTHER Ema B Jacklin

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Marceline Mo

I HEREBY CERTIFY THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J C Davis

(ADDRESS) Richmond Mo

Filed Nov 30, 1913. Geo H Hunt Deputy, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov 30 (Month) (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 24, 1913, to Nov 30, 1913, that I last saw h[illegible] alive on Nov 30, 1913 and that death occurred, on the date stated above, at 4.00 m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

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

Contributory (Secondary) ____

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

(Signed) L H Green M. D.

Nov 30 1913 (Address) Richmond 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	DATE OF BURIAL
Marceline Mo	Dec 2, 1913
UNDERTAKER	**ADDRESS**
G E Hamm	Richmond Mo

V. S. No. 2.

MARGIN RESERVED FOR BINDING

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 HEALT
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 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 fr

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

that I last saw h..... alive on ....., 191....

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)..... M.

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

*State the Disease Causing Death, or, in deaths from Violent Causes, st (1) Means of injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, 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.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191
UNDERTAKER	ADDRESS