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 Sullivan

Township Bowman Registration District No. 854 File No. 26675

or Village Primary Registration District No. 6118B Registered No. Six

or City (No. St.; Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Flora Maud Johnson

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH
SEX: Female	COLOR OR RACE: White	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married	DATE OF DEATH: Aug (Month) 20 (Day), 1915 (Year)

DATE OF BIRTH: Feb (Month) 15 (Day), 1886 (Year)

AGE: 29 yrs. 7 mos. 20 ds. If LESS than 1 day, ___ hrs. or ___ min.?

I HEREBY CERTIFY, that I attended deceased from Aug 19, 1915, to Aug 20, 1915, that I last saw her alive on Aug 20, 1915, and that death occurred, on the date stated above, at 1120 A m.

The CAUSE OF DEATH* was as follows:

146 Eclampsia

138

(Duration) ___ yrs. 3 mos. ___ ds.

Contributory (SECONDARY) Probably Convulsions

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

(Signed) U C Weston M.D.

Aug 20, 1915 (Address) Osgood Mo

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

OCCUPATION
(a) Trade, profession, or particular kind of work: House Keeping
(b) General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE (City or town, State or foreign country): Peabody Kans

PARENTS
- NAME OF FATHER: Thomas Huffine
- BIRTHPLACE OF FATHER (City or town, State or foreign country): Salem Iowa
- MAIDEN NAME OF MOTHER: Sina Palmer
- BIRTHPLACE OF MOTHER (City or town, State or foreign country): near Humphrey Mo

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Earl Huffine

(ADDRESS) Osgood, Mo.

PLACE OF BURIAL OR REMOVAL: Camp Ground — DATE OF BURIAL: Aug 21, 1915

UNDERTAKER: Carpenter Bros — ADDRESS: Osgood Mo

Filed Aug 27, 1915 B L Jones REGISTRAR

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 ____________, 191___ (Month) (Day) (Year)
DATE OF BIRTH ____________, 1____ (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.
AGE ______ yrs. ______ mos. ______ ds.	If LESS than 1 day, ___ hrs. or ___ min.?		The CAUSE OF DEATH* was as follows:
OCCUPATION (a) Trade, profession, or particular kind of work ____________			____________
(b) General nature of industry, business, or establishment in which employed (or employer) ____________			____________ (Duration) ______ yrs. ______ mos. ______ ds.
BIRTHPLACE (City or town, State or foreign country)			Contributory (SECONDARY) ____________ (Duration) ______ yrs. ______ mos. ______ ds.
PARENTS — NAME OF FATHER			(Signed) ____________ M. D.
PARENTS — BIRTHPLACE OF FATHER (City or town, State or foreign country)			________, 191___ (Address) ____________
PARENTS — MAIDEN NAME OF MOTHER			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
PARENTS — BIRTHPLACE OF MOTHER (City or town, State or foreign country)			LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			Where was disease contracted if not at place of death? ____________
(Informant) ____________			Former or usual residence ____________
(ADDRESS) ____________			PLACE OF BURIAL OR REMOVAL ____________ DATE OF BURIAL ________, 191___
Filed ____________, 191___, ____________ REGISTRAR			UNDERTAKER ____________ ADDRESS ____________