

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 Sturgeon
Township _____
or _____
Village _____
or _____
City Kennett Mo (NO. _____ St.; _____ Ward)

Registration District No. 288 File No. 20916
Primary Registration District No. 4172 Registered No. 59

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

FULL NAME Woodrow Wilson Dye

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE S
~~MARRIED~~
~~WIDOWED~~
~~OR DIVORCED~~
(Write the word)

DATE OF BIRTH Jan 22, 1916
(Month) (Day) (Year)

AGE 3 yrs 3 mos 22 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) Kennett Mo

PARENTS
NAME OF FATHER Dave Dye
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ill
MAIDEN NAME OF MOTHER Back
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ill

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dave Dye
(ADDRESS) Kennett Mo

Filed Jan 1, 1916 by W. H. Dye REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 14, 1916
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 1, 1916 to May 14, 1916, that I last saw him alive on May 14, 1916, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
107A
(Duration) 91 yrs. 14 mos. 14 ds.

Contributory P. P. Gage
(Secondary) (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) W. P. Gage M. D.
May 15, 1916 (Address) Kennett 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 Oak Ridge Cem DATE OF BURIAL 5-15, 1916
UNDERTAKER A. C. Lunsell ADDRESS Kennett Mo

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

PLACE OF DEATH

County.....
 Township..... or.....
 Village..... or.....
 City..... (NO.) St.;..... Ward)
 Registration District No. File No.
 Primary Registration District No. Registered No.

(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)....., (Year).....	
AGEyrs.,.....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
 (City or town, State or foreign country).....

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

MAIDEN NAME OF MOTHER
 (City or town, State or foreign country).....

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)....., 191..... (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.
 (Duration).....yrs.....mos.....ds.
 (Signed)....., 191..... (Address)..... M. D.

*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. 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
.....

Parents