

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

Newton

Township

or

Village

or

City

Neasho

(NO.)

St.

Ward

FULL NAME

Ella R. CrumblissMISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No.

609

File No.

6135

Primary Registration District No.

4363

Registered No.

17

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

PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

DATE OF BIRTH

Dec 11, 1867
(Month) (Day) (Year)

AGE

44 yrs. 2 mos. 16 ds.

If LESS than
1 day, ___ hrs.
or ___ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work

Nurse wife

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE

(City or town, State or foreign country)

Hortonville Mo

PARENTS

NAME OF FATHER

John Shepper

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Ohio

MAIDEN NAME OF MOTHER

Ellen Hartman

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A S Crumbliss

(ADDRESS)

Neasho Mo

Filed

Feb 29, 1912W R Watson
Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

July 27, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from

1910, to 1912that I last saw her alive on July 27, 1912and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis231(Duration) 3 yrs. ___ mos. ___ ds.

Contributory

(SECONDARY)

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

(Signed)

Horace Bowers M. D.July 29, 1912 (Address) Neasho 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

9007 Lameba

DATE OF BURIAL

Feb 29, 1912

UNDERTAKER

F. B. Hughes

ADDRESS

Neasho Mo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

PLACE OF DEATH

County _____

Township _____

or

Village _____

or

City _____

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

(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 _____, _____, 19____ (Month) _____ (Day) _____ (Year)		
AGE _____, 19____, to _____, 19____ that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m. 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) _____		
BIRTHPLACE (City or town, State or foreign country) _____		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
_____, _____, 19____ (Month) _____ (Day) _____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 19____, to _____, 19____,
that I last saw him _____ alive on _____, 19____,
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows: _____

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 _____, 19____

REGISTRAR

Contributory

(SECONDARY)

(Signed) _____

_____, 19____ (Address) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Duration) _____ yrs. _____ mos. _____ ds.

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. 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

UNDERTAKER

ADDRESS