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 Jasper

Township ~~Joplin~~ or Village or City Joplin (NO. 32 & Grand St.; Ward)

Registration District No. 411 File No. 5651

Primary Registration District No. 2002 Registered No. 45

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

FULL NAME Eva Titus

**PERSONAL AND STATISTICAL PARTICULARS**

SEX Fem. COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

DATE OF BIRTH Mar (Month) 2 (Day), 1885 (Year)

AGE 27 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.?

OCCUPATION (a) Trade, profession, or particular kind of work House Work

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

BIRTHPLACE (City or town, State or foreign country) New York State

PARENTS

NAME OF FATHER Chancuy Shade

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

MAIDEN NAME OF MOTHER Rosy Graham

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ithaca N.Y.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Titus

(ADDRESS) 32 & Grand av

Filed Feb 5, 1913. A. M. Grega REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH Feb (Month) 1 (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 25, 1913, to Feb 1, 1913, that I last saw her alive on Feb 1, 1913, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Organic Valvular

N.A. Heart disease

(mitral)

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) A N Winchester M. D.

Feb 2, 1913 (Address) Joplin

*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 Mt Calvary

DATE OF BURIAL Feb 4 1913

UNDERTAKER Hurlbut

ADDRESS Joplin

# 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<br>MARRIED<br>WIDOWED<br>OR DIVORCED<br>(*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 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<br>_____, 191____ |
|---|---|
| UNDERTAKER | ADDRESS |

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