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 Johnson

Township or Village or City Knob Noster (NO. ____ St.: ____ Ward)

Registration District No. 429 File No. 23302

Primary Registration District No. 4255 Registered No. 84

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

FULL NAME Eula Maifair Marshall

PERSONAL AND STATISTICAL PARTICULARS

SEX Female

COLOR OR RACE White

SINGLE ~~MARRIED~~ ~~WIDOWED~~ OR DIVORCED (Write the word) single

DATE OF BIRTH Sept. (Month) 5 (Day), 1913 (Year)

AGE 21 yrs. 9 mos. 5 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country) Johnson County

PARENTS
NAME OF FATHER B. F. Marshall
BIRTHPLACE OF FATHER (City or town, State or foreign country) Johnson Co. S
MAIDEN NAME OF MOTHER Nelly G Parker
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Pettis Co.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B F Marshall

(ADDRESS) Knobnoster

Filed 7-13, 1913. W C Knaus REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 11 (Month) (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from April, 1913, to July 11, 1913, that I last saw her alive on July 10, 1913, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

23 A

(Duration) about one year ds.

Contributory (SECONDARY) unknown

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

(Signed) Henry Park M. D.

July 13, 1913 (Address) Knob Noster 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~~ Knob Noster Mo

DATE OF BURIAL 7/13, 1913

UNDERTAKER C. L. Saults

ADDRESS Knob Noster Mo

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 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 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 ....., 191.....
UNDERTAKER	ADDRESS

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.