

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 Pellis
Township _____
or _____
Village _____
or _____
City Lebanon Mo. (NO. 10 Park St.; _____ Ward)

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

Registration District No. 668 File No. 37044
Primary Registration District No. 3032 Registered No. 259

FULL NAME Julia Ingemiska Atkinson

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

PERSONAL AND STATISTICAL PARTICULARS

SEX female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED married
(Write the word)

DATE OF BIRTH June 8 - 5, 1891
(Month) (Day) (Year)

AGE 23 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) —G-O

BIRTHPLACE
(City or town, State or foreign country) Missouri

PARENTS
NAME OF FATHER Chas W. Leftwich
BIRTHPLACE OF FATHER (City or town, State or foreign country) Missouri
MAIDEN NAME OF MOTHER Julia Shaw
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Aug Atkinson

(ADDRESS) Lebanon Mo.

Filed Nov. 7, 1913. H. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov. 7, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct. 17, 1913, to Nov. 7, 1913, that I last saw he alive on Nov. 7, 1913, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

1 Typhoid Fever

(Duration) _____ yrs. _____ mos. 21 ds.

Contributory none
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Chas. J. ... M. D.
Nov. 7, 1913 (Address) Sedalia 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) none
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 Home Keel Pen DATE OF BURIAL Nov. 9, 1913.
UNDERTAKERS M. Laughlin Bros ADDRESS Lebanon Mo.

PLACE OF DEATH

County _____
 Township _____
 or _____
 Village _____
 or _____
 City _____ (NO. _____)

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered 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 _____ (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)

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____, 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.

(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 _____ 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

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.