

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 Pettis

Township _____

or _____

Village _____

or _____

City Bedalia

Registration District No. 668

File No. 40278

Primary Registration District No. 3032

Registered No. 299

(NO. 707 East 17"

St.: _____ Ward) _____

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

FULL NAME George Earp

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE White SINGLE Married
MARRIED Widowed
OR DIVORCED
(Write the word)

DATE OF BIRTH Oct 19, 1873
(Month) (Day) (Year)

AGE 70 yrs. 2 mos. 3 ds. IF LESS than
1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

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

PARENTS
NAME OF FATHER John Earp
BIRTHPLACE OF FATHER England
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Mary Fox
BIRTHPLACE OF MOTHER England
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) David Earp

(ADDRESS) Bedalia mo

Filed Nov 22 1913 H. B. Long
By M. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 12 22, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 1st, 1913, to 12-20, 1913, that I last saw him alive on 12-19, 1913, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH was as follows:
Bright Disease of heart
complicated
131

(Duration) 4 yrs. ____ mos. ____ ds.
Contributory Bright Disease
(SECONDARY)

(Duration) 4 yrs. ____ mos. ____ ds.
(Signed) H. H. Greenfield M. D.
12-22 1913 (Address) 1510 Ohio St

*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 Catholic Cemetery DATE OF BURIAL Dec 23 1913

UNDERTAKER M. Laughlin Bros ADDRESS Bedalia

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 (If file the word)
DATE OF BIRTH		
(Month).....(Day)....., 191.....(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
FATHERBIRTHPLACE
OF FATHER

(City or town, State or foreign country)

MAIDEN NAME
OF MOTHERBIRTHPLACE
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).....(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.....IN.

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. 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

191.....

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

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CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.