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: Adair

Township: ____ or Village: ____ or City: Kirksville (NO. 216 W. Porter ave. St.; 2nd Ward)

Registration District No. 4 — File No. 3767

Primary Registration District No. 3001 — Registered No. 164

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

FULL NAME Humphrey willis Richards

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	Colored	Single

DATE OF BIRTH: April (Month) 21 (Day), 1882 (Year)

AGE: 31 yrs. 9 mos. 20 ds. — If LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE (City or town, State or foreign country): Adair County

PARENTS
NAME OF FATHER: Andrew Richards
BIRTHPLACE OF FATHER (City or town, State or foreign country): Alabama
MAIDEN NAME OF MOTHER: Laura Eubanks
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Marion County

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. E. Richards

(ADDRESS) Kirksville Mo.

Filed Feb 12 1914 — A. W. Benson, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Feb. (Month) 10 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from May 29, 1913, to Feb. 10, 1914, that I last saw him alive on Feb. 10, 1914, and that death occurred, on the date stated above, at 6.30 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

T.B.

Don't Know (Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY) ✓

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) E. C. Gray M. D.

2-12 1914 (Address) Kirksville 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: Llewellyn Cem. — DATE OF BURIAL: Feb 12 1914

UNDERTAKER: H C Wilson — ADDRESS: Kirksville

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.....

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