PLACE OF DEATH

County Jasper

Township ____ or Village ____ or City Webb City (NO. ____, ____ St.; ____ Ward)

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

39189

Registration District No. 417 File No. ____

Primary Registration District No. 3021 Registered No. 205

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

FULL NAME Fern Kerby.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Child

DATE OF BIRTH: Sept. (Month) 27 (Day), 1912 (Year)

AGE: 2 yrs. 2 mos. 14 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Child 7
(b) General nature of industry, business, or establishment in which employed (or employer): Child 27

BIRTHPLACE (City or town, State or foreign country): Webb City, Mo.

PARENTS
NAME OF FATHER: Pleas Kirby
BIRTHPLACE OF FATHER (City or town, State or foreign country): Ill.
MAIDEN NAME OF MOTHER: Ferda Kirby
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ohio.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ferda Kirby

(ADDRESS) Webb City, Mo.

Filed Dec 12, 1914. L. C. Chuzawith REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Dec. (Month) 11 (Day), 1914 (Year) 12.30 a.m.

I HEREBY CERTIFY, that I attended deceased from 6th of Dec, 1914, to Dec 10", 1914, that I last saw her alive on the 10" Dec, 1914, and that death occurred, on the date stated above, at 12 30 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, Superinduced by Measles — of Shoulder Joint.

(Duration) 22 yrs. 3 mos. ____ ds.

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

(Signed) H. C. Manary MOD.

Dec 12, 1914 (Address) 124 N. Webb St. Webb City

*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: Carterville Cem.

DATE OF BURIAL: Dec. 12, 1914

UNDERTAKER: Webb City Und Co

ADDRESS: Webb City, 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