WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT

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

7851

PLACE OF DEATH

County Christian

Township or Village Sparta or City Mo (NO. ____ St.; ____ Ward)

Registration District No. 185 File No. ____

Primary Registration District No. 4111 Registered No. 5

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

FULL NAME Josie Calvin

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

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

DATE OF BIRTH: 4 (Month) 21 (Day), 1879 (Year)

AGE: 35 yrs. ____ mos. ____ ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE (City or town, State or foreign country): Cooper Co Mo

PARENTS
NAME OF FATHER: Johnson Boles
BIRTHPLACE OF FATHER (City or town, State or foreign country): Ind
MAIDEN NAME OF MOTHER: Emaline Rains
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emaline Boles

(ADDRESS) Chadwick Mo

Filed Mar 10, 1915 R. R. Farthing REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: 2 (Month) 19 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 6, 1915, to 2-10, 1915, that I last saw her alive on 2-10, 1915, and that death occurred, on the date stated above, at one a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs.

(Duration) 2 yrs. 28 mos. ____ ds.

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

(Signed) M M Lane M. D.

2-19, 1915 (Address) Sparta 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: Oddfellows Cem

DATE OF BURIAL: Feb 20, 1915

UNDERTAKER: J. M. Barnes

ADDRESS: Sparta Mo

PLACE OF DEATH

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

Revised United States Standard Certificate

County.....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred hospital or instit give its NAME i of street and numb

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

....., 19 (Month) (Day) (Y

I HEREBY CERTIFY, that I attended deceased

....., 191...., to ....., 19

that I last saw h..... alive on ....., 19

and that death occurred, on the date stated above, at .....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. .....

Contributory ..... (SECONDARY)

..... (Duration) ..... yrs. ..... mos. .....

(Signed) .....

....., 191.... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. .....

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 19
UNDERTAKER	ADDRESS