

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

1 PLACE OF DEATH

County DeKalb  
Township Park

Registration District No. 5864  
Primary Registration District No. 360

File No. 21425  
Registered No. \_\_\_\_\_

Village \_\_\_\_\_ or \_\_\_\_\_ City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

2 FULL NAME Julia Ann Ebersold

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX Female 4 COLOR OR RACE White 5 SINGLE  MARRIED  WIDOWED  OR DIVORCED  (Write the word) widow

10 DATE OF DEATH July 13 1915  
(Month) (Day) (Year)

6 DATE OF BIRTH April 8 1843  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from July 13 1915 to July 13 1915 that I last saw her alive on \_\_\_\_\_ 1915 and that death occurred, on the date stated above, at 7 a. m.

7 AGE 72 yrs. 3 mos. 4 ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

The CAUSE OF DEATH\* was as follows:

87 A Apoplexy

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

64 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

9 BIRTHPLACE (City or town, State or foreign country) Ohio

CONTRIBUTORY (Secondary) \_\_\_\_\_

PARENTS 10 NAME OF FATHER A Fisher 11 BIRTHPLACE OF FATHER (City or town, State or foreign country) don't know 12 MAIDEN NAME OF MOTHER don't know 13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) "

(Signed) E M Reynolds M. D. (Address) Union Star Mo July 15 1915

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Clara W Ebersold (Address) Union Star

18 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 \_\_\_\_\_

15 Filed July 14 1915 E M Reynolds Registrar

19 PLACE OF BURIAL OR REMOVAL W L O Grob DATE OF BURIAL July 15 1915 20 UNDERTAKER Oak Grove ADDRESS Union Star Mo

