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

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 Jasper

Township Sarcoxie

or

Village

or

City Sarcoxie Mo (NO. ____ St.: ____ Ward)

Registration District No. 416

Primary Registration District No. 4248

File No. 22106

Registered No. 24

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

FULL NAME Pearl Valentine Read

PERSONAL AND STATISTICAL PARTICULARS

SEX Female

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

DATE OF BIRTH Mar (Month) 25 (Day), 1894 (Year)

AGE 21 yrs. 3 mos. 11 ds.

If LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE (City or town, State or foreign country) Tulsa Okla

PARENTS

NAME OF FATHER Wm Roper

BIRTHPLACE OF FATHER (City or town, State or foreign country) Louisville

MAIDEN NAME OF MOTHER Laura Bosing

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Lawrence Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr J H Read

(ADDRESS) Sarcoxie Mo

Filed July 8, 1915. Leroy Simmons REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July (Month) 7 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from June 25, 1915, to July 6, 1915, that I last saw her alive on Abt July 6, 1915, and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) 01 yrs. ____ mos. 11 ds.

Contributory (SECONDARY)

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

(Signed) J H Cravens M. D.

7/7 1915 (Address) Sarcoxie 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 Boucher Cem

DATE OF BURIAL [illegible], 1915

UNDERTAKER [illegible]

ADDRESS Sarcoxie Mo

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

PLACE OF DEATH

County: Jasper

Township or Village: Sarcoxie

or City: Sarcoxie (NO. ____, ____ St.; ____ Ward)

Registration District No. ____ File No. ____

Primary Registration District No. ____ Registered No. ____

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

FULL NAME Pearl Valentine Read

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
female	White	Single

DATE OF BIRTH: Mar (Month) 25 (Day), 1894 (Year)

AGE: 21 yrs. 3 mos. 11 ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE (City or town, State or foreign country): Tulsa Okla

PARENTS
- NAME OF FATHER: Wm Roper
- BIRTHPLACE OF FATHER (City or town, State or foreign country): ____
- MAIDEN NAME OF MOTHER: Laura Boswell
- BIRTHPLACE OF MOTHER (City or town, State or foreign country): Lawrence Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Wm J H Read

(ADDRESS): Sarcoxie Mo

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 ____ 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
Boucher Cem	7/8, 1915
UNDERTAKER	ADDRESS
[illegible]	Sarcoxie Mo

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

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