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.

Dr Baker

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

PLACE OF DEATH

County Jasper

Township ~~Marion~~

or

Village

or

City Carthage (NO. ..... St.: ..... Ward)

Registration District No. 408 File No. 35381

Primary Registration District No. 3020 Registered No. 207

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

FULL NAME Joe A Searle

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH April (Month) (Day), 1913 (Year)

AGE 4 yrs. — mos. — ds. | If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Oklahoma

PARENTS
NAME OF FATHER Walter Searle
BIRTHPLACE OF FATHER (City or town, State or foreign country) Nebr.
MAIDEN NAME OF MOTHER Ella Simmons
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Lebanon Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter Searle

(ADDRESS) Big Heart Okla

Filed Oct. 6, 1917 C B Taylor REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct. (Month) 5 (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 3, 1917, to Oct 5, 1917, that I last saw her alive on Oct 5, 1917, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs & Bowels

2.3 A

2.5 (Duration) 2.8 yrs. ..... mos. ..... ds.

1.0 Contributory (SECONDARY) Indigestion

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

(Signed) R E Baker M. D.

10/7, 1917 (Address) Carthage 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 Oak Hill | DATE OF BURIAL Oct 6, 1917

UNDERTAKER Knell Undg Co | ADDRESS Carthage

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 .....

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.

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