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 Jasper

Township Joplin

or

Village Royal Heights

or

City (NO. St. Ward)

Registration District No. 417 File No. 26773

Primary Registration District No. 5561D Registered No. 167

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

2 FULL NAME Lucretia Delaplaine

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH April 3, 1849 (Month) (Day) (Year)

7 AGE 69 yrs. 4 mos. 20 ds. If LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Ill.

PARENTS

10 NAME OF FATHER Wm Eberman

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) No record

12 MAIDEN NAME OF MOTHER Sarah no record

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) No record

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. B. Delaplaine

(Address) Grandby Mo.

15 Filed Aug. 24th, 1918 C. E. McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 23, 1918 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from June 20, 1918, to Aug 12, 1918, that I last saw her alive on Aug 12, 1918, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Epitheloma

52 (Cancer of Face)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. D. Growden M. D.

8/23, 1918 (Address) Webb City Mo

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

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

19 PLACE OF BURIAL OR REMOVAL Mt Hope Cem

DATE OF BURIAL 8/24, 1918

20 UNDERTAKER W. K. Hurlbut

ADDRESS Joplin Mo.

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

1 PLACE OF DEATH

County .....

Township..... or Village ..... or City..... (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.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH

.....(Month) .....(Day), 1.....(Year)

7 AGE

.....yrs.....mos.....ds.

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

8 OCCUPATION
(a) Trade, profession, or particular kind of work.....

(b) General nature of industry business or establishment in which employed (or employer) .....

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

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address).....

15

Filed..... ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

.....(Month) .....(Day), 191.....(Year)

17 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.

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.....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191.....
20 UNDERTAKER	**ADDRESS**

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.