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

1 PLACE OF DEATH

County Jasper

Township Joplin
or
Village
or
City Webb City

Registration District No. 417 File No. 29698

Primary Registration District No. 3021 Registered No. 176

(NO. ..... St.: ..... Ward)

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

2 FULL NAME Josephine E. Myers

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem

4 COLOR OR RACE wht

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

6 DATE OF BIRTH Feb. (Month) 19 (Day), 1918 (Year)

7 AGE — yrs. 7 mos. 26 ds. If LESS than 1 day, ... hrs. or ..... min.?

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

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

PARENTS

10 NAME OF FATHER Jim C. Myers

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

12 MAIDEN NAME OF MOTHER Daily Goodnight

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jim C. Myers

(Address) Webb City Mo

15 Filed Sept. 15th, 191 C. E. McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept (Month) 15 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Aug. 22nd, 1918, to Aug. 22nd, 1918, that I last saw her alive on Aug. 22nd, 1918, and that death occurred, on the date stated above, at 12.30 P.m.

The CAUSE OF DEATH* was as follows:

Entero Colitis

1198 104

(Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) ——

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

(Signed) C. H. Craig M. D.

Sept. 14th, 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 Webb City Cem

DATE OF BURIAL Sept 16, 1918

20 UNDERTAKER Stratmund Co

ADDRESS Webb City

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

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.

1 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.]

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