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 or Village or City: Webb City

Registration District No. 417 File No. 29703

Primary Registration District No. 3021 Registered No. 184

Jasper Co. Tuberculosis Hospital St. Ward

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

FULL NAME George Kramm

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write word): Married

DATE OF BIRTH: Aug. 11, 1875 (Month) (Day) (Year)

AGE: 43 yrs. 1 mos. 9 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer): Lead & Zinc

BIRTHPLACE (City or town, State or foreign country): Unknown

PARENTS
NAME OF FATHER: Julius Kramm
BIRTHPLACE OF FATHER (City or town, State or foreign country): Germany
MAIDEN NAME OF MOTHER: Unknown
BIRTHPLACE OF MOTHER (City or town, State or foreign country): " "

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs George Kramm

(ADDRESS) Carterville Mo.

Filed Sept. 21st 1918 C. E. McBride REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Sept 20 (Month) (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 13, 1918, to Sept 20, 1918, that I last saw him alive on Sept 20, 1918, and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

78

Pulmonary Tuberculosis

23A

(Duration) 2 yrs. ___ mos. ___ ds.

Contributory (SECONDARY)

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

(Signed) Leo A Stock M. D.

Sept 21, 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.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. 7 ds. In the State 25 yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? Unknown

Former or usual residence: Carterville Mo

PLACE OF BURIAL OR REMOVAL: Carterville Cem

DATE OF BURIAL: Sept. 7th 1918

UNDERTAKER: Webb City Und Co.

ADDRESS: Webb City.

PLACE OF DEATH

County _____

Township _____ or Village _____ or City _____ (NO. _____, _____ St.; _____ Ward)

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

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 _____

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 _____ (Month) _____ (Day), 1_____ (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 _____ (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 _____, 191____

UNDERTAKER | ADDRESS