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: Camden

Township or Village or City: Linn Creek

Registration District No. 117 — File No. 32111-A

Primary Registration District No. 4065 — Registered No.

(NO. ____ St.: ____ Ward)

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

FULL NAME Joel Eidson Parrish

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: W

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): married

DATE OF BIRTH: Aug (Month) 20 (Day), 1901 (Year)

AGE: 17 yrs. 2 mos. 1 ds. — If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country): Camden Co Mo

PARENTS
NAME OF FATHER: A. B. Eidson
BIRTHPLACE OF FATHER (City or town, State or foreign country): Camden Co Mo
MAIDEN NAME OF MOTHER: Elizabeth Byers
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Cooper Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A B Eidson

(ADDRESS) Linn Creek Mo

Filed Dec 26, 1918 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct (Month) 21 (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 10, 1918, to Oct 21, 1918, that I last saw her alive on Oct 21, 1918, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

107A

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

Contributory (SECONDARY)

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

(Signed) Geo. W Moore M. D.

Dec 26, 1918 (Address) Linn Creek 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: Linn Creek Country

DATE OF BURIAL: Oct 22, 1918

UNDERTAKER: No

ADDRESS

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE 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 _____

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____, 191____, _____ (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) _____

DATE OF BURIAL (ADDRESS) _____

UNDERTAKER _____ 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 this 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 _____

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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