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.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

40387

1 PLACE OF DEATH

County Jasper

Township Mineral

or

Village

or

City Near Webb City (No. Jasper Co. Tube Hosp St.; Ward)

Registration District No. 413 File No.

Primary Registration District No. 5559 Registered No. 5037

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

2 FULL NAME Nellie Z Hill

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 July (Month) 4 (Day) 1899 (Year)

7 AGE 19 yrs. 3 mos. 29 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) Duenweg Mo

PARENTS

10 NAME OF FATHER James S Tucker

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

12 MAIDEN NAME OF MOTHER Jane Martin

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Cedric Tucker

(Address) Joplin Mo

15

Filed Nov 10, 1918. J. H. Barnes M.D. by H. Barnes Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov (Month) 2 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 10, 1918, to Nov 2, 1918, that I last saw her alive on Nov. 2, 1918, and that death occurred, on the date stated above, at 9:20 A m.

The CAUSE OF DEATH* was as follows:

28

Tuberculous Meningitis

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Pul. Tuberculosis

(Duration) 11 yrs. ....mos. ....ds.

(Signed) Geo A Stock M. D.

Nov. 2, 1918 (Address) Webb City

*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. 1 mos. 22 ds. In the State ....yrs. ....mos. ....ds.

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

Former or usual residence Joplin Mo.

19 PLACE OF BURIAL OR REMOVAL Fairview Cem.

DATE OF BURIAL 11-3, 1918

20 UNDERTAKER [illegible]

ADDRESS [illegible]

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

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) ....., 1..... (Day) (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..... .....

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**