MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 40418

1 PLACE OF DEATH

County: Jasper

Township: ... or Village: Lehurcuasses ... or City: Carterville (NO. ... St.: ... Ward)

Registration District No.: 417 Primary Registration District No.: 3021

File No.: ... Registered No.: 262

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

2 FULL NAME James Redmond

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: Oct. 1 (Month) (Day) 1879 (Year)

7 AGE: 39 yrs. 1 mos. 10 ds. If LESS than 1 day ... hrs. or ... min.?

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

9 BIRTHPLACE (City or town, State or foreign country): Mulberry - Kans

PARENTS

10 NAME OF FATHER: Jas. Redmond

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

12 MAIDEN NAME OF MOTHER: Manirva Lincoln

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs Ruth Redmond
(Address): Webb City Mo.

15 Filed: Nov. 16, 1918. C. E. McPherson, Registrar

3 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov 10 (Month) (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 16, 1918, to Nov. 10, 1918, that I last saw him alive on Nov 9, 1918, and that death occurred, on the date stated above, at 6:45 a.m.

The CAUSE OF DEATH* was as follows:

(Mitral Stenosis
Acute Endocarditis

(Duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary): Pul Tuberculosis

(Duration) ... yrs. 6 mos. ... ds.

(Signed) L. A. Stock M. D.

Nov. 11, 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. 1 mos. 25 ds. In the State ... yrs. ... mos. ... ds.

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

Former or usual residence: Webb City

19 PLACE OF BURIAL OR REMOVAL: Carterville Cem. DATE OF BURIAL: 11/17, 1918

20 UNDERTAKER: McHenry Und. Co ADDRESS: Webb City

NOTE: 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

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

....., 1.....
(Month) (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....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

....., 191.....
(Month) (Day) (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. PARTICULARS should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.