Dr Freeman

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

PLACE OF DEATH

County: Jasper

Township or Village: Balena

City: Joplin (NO. ____ St.: ____ Ward)

Registration District No. 411 File No. 6217

Primary Registration District No. 2002 Registered No. 128

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

FULL NAME Mary T. Stanley

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

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

DATE OF BIRTH: December 8th, 1882 (Month) (Day) (Year)

AGE: 37 yrs. 2 mos. 5 ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE (City or town, State or foreign country): St. Louis Mo.

PARENTS

NAME OF FATHER: Thos Gaffney

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

MAIDEN NAME OF MOTHER: Dort Brum

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. Stanley

(ADDRESS) Joplin Mo

Filed Feb 14 1919 J. A. Chenoweth REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: July 12, 1919 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 9, 1919, to 7-12, 1919, that I last saw her alive on 7-12, 1919, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia
Effusion - Bilateral
11A
109A (Duration) ____ yrs. ____ mos. 5 ds.

Contributory (SECONDARY) Influenza
(Duration) ____ yrs. ____ mos. 9 ds.

(Signed) R M James M. D.
7-14 1919 (Address) Joplin, 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: Forest Park Cem

DATE OF BURIAL: Feb 15 1919

UNDERTAKER: James Forman

ADDRESS: Joplin Mo

MISSOURI STATE BOARD
BUREAU OF VITAL STA
CERTIFICATE OF DEA

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____
or
Village _____ Primary Registration District No. _____ Registered No. _____
or
City _____ (NO. _____ _____ St.; _____ Ward)

FULL NAME _____

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 DE

DATE OF DEATH _____ (Month)

I HEREBY CERTIFY, that I atte
_____, 191____, to _____
that I last saw h_____ alive on _____
and that death occurred, on the date stated
The CAUSE OF DEATH* was as follows:

_____
_____
_____
_____ (Duration) _____ yrs. _____

Contributory _____
(SECONDARY)
_____ (Duration) _____ yrs. _____

(Signed) _____

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths fro
(1) Means of Injury; and (2) whether Accidental, Suicidal, or

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUT
RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs.

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

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL | DATI

UNDERTAKER | ADD

able terms and refuse to accept certificates not in conformity with the form. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report