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

PLACE OF DEATH

County Jasper

Township ~~Galena~~ or Village or City Joplin (NO. ____ St.: ____ Ward)

Registration District No. 411 File No. 10304 10028

Primary Registration District No. 2002 Registered No. 177

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

FULL NAME Mary Elizabeth Moreum

PERSONAL AND STATISTICAL PARTICULARS

SEX Female

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widowed

DATE OF BIRTH Mar (Month) 4 (Day), 1851 (Year)

AGE 68 yrs. ____ mos. 2 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) Household duties

BIRTHPLACE (City or town, State or foreign country) Smithville Ark.

PARENTS
NAME OF FATHER John Park
BIRTHPLACE OF FATHER (City or town, State or foreign country) North Carolina
MAIDEN NAME OF MOTHER Narcissa Winders
BIRTHPLACE OF MOTHER (City or town, State or foreign country) South Carolina

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. J. Park

(ADDRESS) Washburn Mo.

Filed Mar 6 1919 J. A. Chenoweth REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar 6 (Month) (Day), 1919 (Year)

I HEREBY CERTIFY, that I attended deceased from March 4, 1919, to March 6, 1919, that I last saw her alive on March 5, 1919, and that death occurred, on the date stated above, at 5 m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency 72
General Dropsy 12

(Duration) ____ yrs. 4 mos. ____ ds.

Contributory (SECONDARY) Nephritis Hart Lesion

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) A E Cuny M. D.

March 6 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

DATE OF BURIAL Mar 7 1919

UNDERTAKER Jarvis-Forman

ADDRESS Joplin Mo

PLACE OF DEATH

County _____

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

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

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occu
hospital or in
give its NAME
of street and nu

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____, 1_____
(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) _____

(ADDRESS) _____

Filed _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, _____
(Month) (Day)

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

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos.

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

(Signed) _____

_____, 191____ (Address) _____

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRA
RECENT RESIDENTS)

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

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

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURI
UNDERTAKER	ADDRESS