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

1 PLACE OF DEATH

County: Jasper

Township: ..... or Village: ..... or City: ~~Joplin~~ Webb City

Registration District No. 417 — Primary Registration District No. 304

File No. 19969 — Registered No. 116

(NO. Jasper Co Sub. Hosp. St.; Ward)

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

2 FULL NAME Mrs Mable Markley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: Unknown (Month) (Day) (Year)

7 AGE: About 50 yrs. ..... mos. ..... ds. — If LESS than 1 day, ... hrs. or ..... min.?

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

9 BIRTHPLACE (City or town, State or foreign country): Unknown

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) Hephena Hamilton
(Address) Joplin Mo

15 Filed 6/16 1919 C. E. McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 14 (Day) 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from June 12 1919, to June 13 1919, that I last saw her alive on June 13 1919, and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis 23A 28

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

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. L. Rader M. D.
6-14 1919 (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. ..... 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: Fairview cem — DATE OF BURIAL: June 12 1919

20 UNDERTAKER: Frank Lemon — ADDRESS: Joplin

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

1 PLACE OF DEATH

County .....

Township ..... or

Village ..... or

City ..... (NO. ....., ... St.; ..... Ward)

MISSOURI STATE BOARD OF HE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. .....

Primary Registration District No. .....

File No. .....

Registered No. .....

(If death oc hospital or give its NAM of street and

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

..... (Month) ..... (Day) ....., 19

17 I HEREBY CERTIFY, that I attended deceas

....., 191....., to ....., 1

that I last saw h.....alive on ....., 1

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 Ca (1) Means of Injury; and (2) whether Accidental, Suicidal or Ho

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tr or 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 .....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS