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

22658

1 PLACE OF DEATH

County Jasper

Township ..... Registration District No. 417 File No. .....

or

Village ..... Primary Registration District No. 3021 Registered No. 124

or

City ~~Joplin~~ Webb City Mo (No. Jasper Cov T B Hospital Ward)

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

2 FULL NAME Anna Crane

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) widow

6 DATE OF BIRTH Dec (Month) 9 (Day) 1854 (Year)

7 AGE 64 yrs. 6 mos. 22 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry business or establishment in which employed (or employer) "

9 BIRTHPLACE (City or town, State or foreign country) Illinois

PARENTS

10 NAME OF FATHER W. T. Hurst

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

12 MAIDEN NAME OF MOTHER Dent Knox

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. M. Meese

(Address) Webb City Mo

15 Filed July 9th 1919 C. E. McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July (Month) 7 (Day) 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from 6-13 1919 to 7-4 1919

that I last saw her alive on July 6 1919

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis 28

23

(Duration) 210 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

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

(Signed) H. L. Nattell M. D.

7-8 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. 3 mos. 2 ds. In the State 43 yrs. ..... mos. ..... ds.

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

Former or usual residence Joplin Mo

19 PLACE OF BURIAL OR REMOVAL Farmer

DATE OF BURIAL July 9 1919

20 UNDERTAKER Frank-Sievers Co

ADDRESS Joplin Mo

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....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ....., 191..... (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**