LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—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.

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

1 PLACE OF DEATH

County Jasper

Township ..... Registration District No. 417 File No. 36455

or

Village ..... Primary Registration District No. 3021 Registered No. 216

or

City Webb City (NO. Jasper Co. Pub. Hosp. St., Ward)

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

2 FULL NAME Mrs. Alice Parrish

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: June (Month) 24 (Day) 1893 (Year)

7 AGE: 26 yrs. 5 mos. 24 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): Eureka Springs Ark

PARENTS

10 NAME OF FATHER: L. A. Chaplin

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

12 MAIDEN NAME OF MOTHER: Dont know

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lafe Parish

(Address) Joplin Mo

15 Filed 12/18, 1919. C. E. McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: December (Month) 18 (Day) 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov. 21, 1919, to Dec 18, 1919, that I last saw her alive on Dec 18, 1919, and that death occurred, on the date stated above, at 8:20 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

28 (Duration) 2 yrs. ..... mos. ..... ds.

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

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

12-18, 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: Neosho Mo

DATE OF BURIAL: 12/19, 1919

20 UNDERTAKER: Myall-Anderson

ADDRESS: Joplin Mo.

36455

MISSOURI STATE BOARD OF HEA
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 occu
hospital or in
give its NAME
of street and n

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

....., 191
(Month) (Day)

17 I HEREBY CERTIFY, that I attended decease
....., 191....., to....., 19
that I last saw h.....alive on....., 19
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 Caus
(1) Means of Injury; and (2) whether Accidental, Suicidal or Hon

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tran
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**

THIS IS A PERMANENT RECORD