V. S. No. 2. A

MARGIN RESERVED FOR BINDING

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

...nty Jasper

...nship

...age Webb City (No. Jasper Co. Tuberculosis Hospital St. Ward)

Registration District No. 417 File No. 11 1775

Primary Registration District No. 3021 Registered No.

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

2 FULL NAME George House

PERSONAL AND STATISTICAL PARTICULARS

...le | 4 COLOR OR RACE White | 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widowed

...TE OF BIRTH unknown (Month) (Day) 1878 (Year)

...E 41 yrs. X mos. X ds. If LESS than 1 day, ...hrs. or ...min.?

...CUPATION Trade, profession, or ...ticular kind of work Miner

General nature of industry ...siness or establishment in ...ich employed (or employer)

...RTHPLACE ...y or town, ...e or foreign country) Missouri

10 NAME OF FATHER Geo. House

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

12 MAIDEN NAME OF MOTHER unknown

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

...HE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Burrows

(Address) Galena R.F.D.4

...iled 1/16 1920 C. E. McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. (Month) 10th (Day) 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from 6-13 1919 to 1-12 1920

that I last saw him alive on 1-13 1920

and that death occurred, on the date stated above, at 1 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary T. B.

23 H

(Duration) 1 yrs. 28 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. L. Rattell M. D.

1-13 1920 (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 1 yrs. 6 mos. ds. In the State yrs. mos. ds.

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

Former or usual residence Joplin Mo

19 PLACE OF BURIAL OR REMOVAL Carterville Cem. DATE OF BURIAL Jan 16 1920

20 UNDERTAKER Webb City Und Co ADDRESS Webb City

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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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 occur
hospital or ins
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
..... (Month) ..... (Day) ....., 191

17 I HEREBY CERTIFY, that I attended deceased
....., 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 Cause
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homi

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans
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
	....., 19
20 UNDERTAKER	**ADDRESS**