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

19753

1 PLACE OF DEATH

unty Jasper

wnship

Registration District No. 417 File No. 113

lage

Primary Registration District No. 2021 Registered No.

y Jasper Co Tuberculosis Hos (Note ..... St.; ..... Ward)

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

2 FULL NAME Lillian B. Carman

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
...nale	White	Widow

TE OF BIRTH Sept. 21, 1893 (Month) (Day) (Year)

E 26 yrs. 8 mos. 22 ds. If LESS than 1 day, ... hrs. or ..... min.?

CUPATION Trade, profession, or rticular kind of work House work

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

RTHPLACE y or town, e or foreign country) Joplin, Mo

10 NAME OF FATHER August H. Tingle

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

12 MAIDEN NAME OF MOTHER Allie Taylor

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

HE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant) Goldie Vancil

(Address) Joplin Mo

Filed 5/13, 1920. D. E. McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May (Month) 12 (Day), 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from May 3, 1920, to May 12, 1920, that I last saw her alive on May 12, 1920, and that death occurred, on the date stated above, at 11-40 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

23A 48

(Duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Varney Hazlewood, M. D.

May 13, 1920. (Address) Webb City Mo Tuberculosis Hospital

*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. 13 ds. In the State unknown yrs. ..... mos. ..... ds.

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

Former or usual residence Joplin Missouri

19 PLACE OF BURIAL OR REMOVAL Fairview DATE OF BURIAL May 14, 1920

20 UNDERTAKER Frank Sievers Co ADDRESS Joplin Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

V. S. No. 2. A

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MISSOURI STATE BOARD OF HEAL

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 hospital or instit give its NAME i of street and num

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.... (Y

17 I HEREBY CERTIFY, that I attended deceased

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

that I last saw h..... alive on ....., 191.

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) ..... M

....., 191..... (Address) .....

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transie 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 ....., 191
20 UNDERTAKER	ADDRESS