LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

4729

1. PLACE OF DEATH
County: Jasper — Registration District No.: 411 — File No.:
Township: — Primary Registration District No.: 2002 — Registered No.: 20
City: Joplin (No. ..... St. ..... Ward)

2. FULL NAME: Charles Edward Geboe

(a) Residence. No. ..... St., ..... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) |
|---|---|---|
| Male | white | widower |

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan 16 1857

| 7. AGE | YEARS | MONTHS | DAYS | IF LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 67 | | 16 | |

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: 0

9. BIRTHPLACE (CITY OR TOWN): Ind
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER: Edward Geboe
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Ind
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER: Mary
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Ind
(STATE OR COUNTRY)

14. INFORMANT: Chas Geboe
(Address): Joplin Mo

15. FILED 2/1/1924 A Bussow Clerk
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH** ✓

16. DATE OF DEATH (MONTH, DAY AND YEAR): Feb 1 1924

17. I HEREBY CERTIFY, That I attended deceased from 1/28/24 2/1/24, 19..., to ..., 19..., that I last saw h... alive on 2/1, 1924, and that death occurred, on the date stated above, at 7 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
108 / 101 C
3 d 8 h (duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (SECONDARY): Cerebral hemorrhage
(duration) ... yrs. ... mos. ... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? no. DATE OF 2/1/24
WAS THERE AN AUTOPSY? no.
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Dr. A. M. Gregg, M. D
2-1, 1924 (Address) Frisco Hotel Joplin Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

| 19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL |
|---|---|
| Baxter Springs | Feb 3 1924 |
| 20. UNDERTAKER: J M Clark | ADDRESS: Galena |

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.

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

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**1. PLACE OF DEATH**

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Township..... Primary Registration District No..... Registered No. .....

City..... (No....., .....St. .....Ward)

**2. FULL NAME** .....

(a) Residence. No..... St., .....Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, .....hrs. or .....min.

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(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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I HEREBY CERTIFY, That I attended deceased from .....
.....,19....., to .....,19.....
that I last saw h..... alive on.....,19....., 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.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....,M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

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