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

38720

PLACE OF DEATH

County Texas

Township ~~Army~~ or Village or City Houston (NO. ..... St.: ..... Ward)

Registration District No. 863 File No. .....

Primary Registration District No. 4522 Registered No. 20

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

FULL NAME Julia Ann Greenia Fitch

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: W

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Widow

DATE OF BIRTH: July (Month) 20 (Day), 1843 (Year)

AGE: 82 yrs. 5 mos. 7 ds. If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): ——

BIRTHPLACE (City or town, State or foreign country): Mo.

PARENTS

NAME OF FATHER: Wm Greenia

BIRTHPLACE OF FATHER (City or town, State or foreign country): ~~Cano~~ Mo

MAIDEN NAME OF MOTHER: Angeline Lapine

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Canada

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ella Fitch

(ADDRESS) Houston

Filed 12-29, 1925. J. R. Womack REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: 12 (Month) 27 (Day), 1925 (Year)

I HEREBY CERTIFY, that I attended deceased from ——, 191..., to ....., 191..., that I last saw her alive on 12-27-, 1925, and that death occurred, on the date stated above, at 2:15 P.M.

The CAUSE OF DEATH* was as follows:

Cause undetermined

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

Contributory (SECONDARY) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. P. Blankenship M. D.

12-29, 1925 (Address) Houston Mo

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

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 .....

PLACE OF BURIAL OR REMOVAL: Houston Mo

DATE OF BURIAL: Dec. 26, 1925

UNDERTAKER: Gaylord V Elliott

ADDRESS: Cabool

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

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]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... , *1*.....
(Month) (Day) (Year)

AGE

..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

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

MAIDEN NAME OF MOTHER

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ..... , 191..... , ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... , *191*.....
(Month) (Day) (Year)

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.

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 .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	..... , 191.....
UNDERTAKER	ADDRESS

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.