

N. B.—Very 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

Do not use this space.

5988

1. PLACE OF DEATH

County JasperRegistration District No. 411

File No. _____

Township MadisonPrimary Registration District No. 2016 Grand Ave

Registered No. _____

City Joplin (No. _____) St. _____ Ward _____2. FULL NAME Mrs. Fannie Madge Kilbreath

(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

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

married

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

Bruce E. Kilbreath

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

Nov 4-1894

7. AGE

YEARS

MONTHS

DAYS

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

2836

8. OCCUPATION OF DECEASED

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

home-maker

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

245

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Arilla mo

(STATE OR COUNTRY)

10. NAME OF FATHER

J. E. Hall

PARENTS

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Iowa

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Lizzie M. Baker

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Arilla mo

(STATE OR COUNTRY)

14. INFORMANT

(Address)

J. E. Hall
Joplin mo

15. FILED

2/12, 1931Abraham Clark

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Feb 10 1931

17. I HEREBY CERTIFY

That I attended deceased from Jan 22 31 to Feb 10 31 that I last saw him alive on 2-10-31 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hypertrophic
cardiomyopathy of Liver

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Anemia

(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) J. H. Johnson phys.(Address) 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Arilla Cem.2/12 31

20. UNDERTAKER

ADDRESS

Newbest and Co Joplin Mo

CLARK

one of
the

U.S.
UA

ART

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jasper
Township _____
City Joplin (No. _____, _____ St. _____ Ward)

Registration District No. 411
Primary Registration District No. 2002

File No. _____
Registered No. _____

2. FULL NAME

Fannie Marge Gilbreath

(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 4 - 1893

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
37 3 6

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

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

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____
(STATE OR COUNTRY)

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 4/20 19 31 Adman Clark

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 10 19 31

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above.

THE CAUSE OF DEATH WAS AS FOLLOWS:

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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

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

N. B. Item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

