

27 1930

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

Do not use this space.

1. PLACE OF DEATH

County Jasper Registration District No. 411 File No. 5375
Township Clinton Primary Registration District No. 2, 0021 Registered No. 93
City Joplin St. _____ Ward _____

2. FULL NAME

Marylou Delpha Drake
(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 MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE W 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) Jan 18 - 1920

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
10 1 7

8. OCCUPATION OF DECEASED Student
(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) Missouri

10. NAME OF FATHER Clate Drake

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

12. MAIDEN NAME OF MOTHER Frances Rose

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

14. INFORMANT (Address) Mrs. Minnie Drake
Joplin, Mo.

15. FILED 2/28, 1930 A. B. Benson REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-25-1930

17. 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 12:25 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Meningitis - not epidemic
1868
1948
79A death injury to spine
CONTRIBUTORS (SECONDARY) in fall (duration) yrs. 8 mos. ago

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH 186

8 DID AN OPERATION PRECEDE DEATH? DATE OF _____

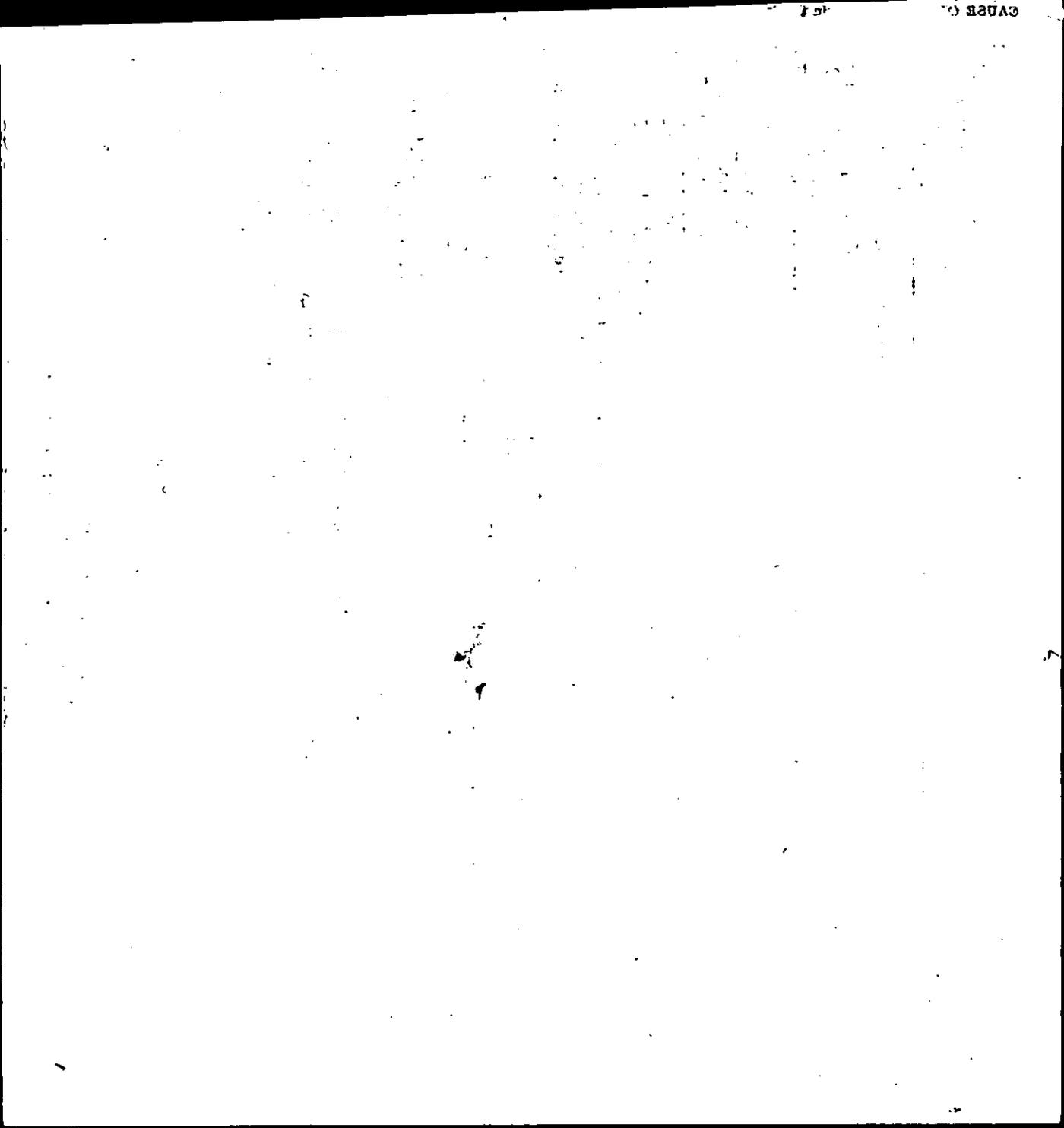
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) W. S. Jewell, M. D.
25, 1930 (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 Fairview DATE OF BURIAL 2/27/30
19

20. UNDERTAKER Fuel and Co ADDRESS Joplin, Mo.



**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 Registration District No. 411 File No. 5375
 Township Primary Registration District No. 2002 Registered No. 93
 City Joplin (No.) St. Ward)

2. FULL NAME

Marjorie Delpha Drake

(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

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 25 19 30

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

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

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

meningitis - not epidemic

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

CONTRIBUTORY (SECONDARY) due to injury to spine in fall from trees (duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....

10. NAME OF FATHER

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

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

WAS THERE AN AUTOPSY.....

12. MAIDEN NAME OF MOTHER

WHAT TEST CONFIRMED DIAGNOSIS.....

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

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

14. INFORMANT (Address) 19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

15. FILED 9/6, 19 30 A. Benson Clark REGISTRAR 20. UNDERTAKER ADDRESS

SUPPLEMENTARY

OF DEATH in plain terms, so that it may be properly understood.

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

