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

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

PLACE OF DEATH

County Jasper

Township ~~Marion~~ or Village or City Carthage (NO. 845 Clinton St. Ward)

Registration District No. 408 Primary Registration District No. 3020

File No. 41678 Registered No. 266

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

FULL NAME Minerva Kung

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Widowed

DATE OF BIRTH June 8 (Month) (Day) 1842 (Year)

AGE 75 yrs. 6 mos. 18 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country) Fayetteville Ark

PARENTS

NAME OF FATHER Gibson

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

MAIDEN NAME OF MOTHER Sally Dutton

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. L. King

(ADDRESS) Carthage

Filed Dec 27, 1917. C. R. Taylor REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec (Month) 26 (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 17, 1917, to Dec 26, 1917, that I last saw her alive on Dec 26, 1917, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Pleurisy 93

1183

97

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

Contributory (Secondary) Arters—Sclerosis

(Duration) ___ yrs. 1 mos. ___ ds.

(Signed) David King M. D.

Dec 27, 1917 (Address) Carthage 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 Carrville Mo

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Carrville Mo	Dec 28, 1917

UNDERTAKER	ADDRESS
Knell Und Co	Carthage

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

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.