

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

PLACE OF DEATH

County Platte
Township Green
or
Village Candem Pt.
or
City _____ (NO. _____ St.: _____ Ward _____)

Registration District No. 691 File No. 2055
Primary Registration District No. 4413 Registered No. 2

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

FULL NAME

Elizabeth Ballard

PERSONAL AND STATISTICAL PARTICULARS

SEX female COLOR OR RACE white SINGLE MARRIED widower WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH Oct 1, 1866
(Month) (Day) (Year)

AGE 47 yrs. 3 mos. 20 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

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

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

NAME OF FATHER William P. George

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

MAIDEN NAME OF MOTHER Fannie Duncanson

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wyatt Ballard
(ADDRESS) Candem Pt.

Filed 1-22, 1914 A. S. Herndon
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 21, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 16, 1914, to Jan 20, 1914, that I last saw her alive on Jan 20, 1914, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:
Hyper Catharsis & Examinations
(Self administered patent
84 medicines)

(Duration) 1 yrs. 3 mos. ds.

Contributory Delusional Insanity
(Secondary) (Duration) 10 yrs. mos. ds.

(Signed) A. S. Herndon M. D.
1-21-1914 (Address) Candem Pt. 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 Candem Point Cemetery DATE OF BURIAL 1-22, 1914

UNDERTAKER Lucian Davis ADDRESS Bagerton Mo.

PLACE OF DEATH

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

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County _____

Township _____

or _____

Village _____

or _____

City _____

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

(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 _____ (Month) _____, 191____ (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) _____

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 _____

(Month) _____, 191____ (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) _____

(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. 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 _____

UNDERTAKER _____

ADDRESS _____