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 Knox

Township Salt River

or

Village

or

City (NO. St.: Ward)

Registration District No. 446

File No. 2035864-A

Primary Registration District No. 5066

Registered No.

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

FULL NAME Elizabeth Poor

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

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

DATE OF BIRTH: June (Month) 20 (Day) 1837 (Year)

AGE: 77 yrs. 5 mos. 7 ds.

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

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

BIRTHPLACE (City or town, State or foreign country): Shelby Co. MO

PARENTS

NAME OF FATHER: Hugh Anderson

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

MAIDEN NAME OF MOTHER: Elizabeth Hair

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Poor

(ADDRESS) Novelty, Mo.

Filed Nov 27, 1914 M. E. Hill
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Nov. (Month) 27 (Day) 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 25, 1914, to Nov 27, 1914, that I last saw her alive on Nov 25, 1914, and that death occurred, on the date stated above, at 1154 m.

The CAUSE OF DEATH* was as follows:

Diabetes

59

(Duration) 4 yrs. — mos. — ds.

Contributory (SECONDARY)

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

(Signed) P. Sherlock M. D.

Nov 27, 1914 (Address) Novelty, 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: Sigbee Marion Co

DATE OF BURIAL: Nov 29, 1914

UNDERTAKER: Jno W Hudson

ADDRESS: Novelty MO

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

..... (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.