LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 2247

1 PLACE OF DEATH

County Monroe

Township Woodlawn or Village or City ..... (NO. ..... St.; ..... Ward)

Registration District No. 587 File No. .....

Primary Registration District No. 1885 Registered No. 3

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

2 FULL NAME Elsie Burnsworth

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

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

6 DATE OF BIRTH April (Month) 15 (Day) 1842 (Year)

7 AGE 74 yrs. 9 mos. 12 ds. If LESS than 1 day, ... hrs. or ..... min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Paris

PARENTS

10 NAME OF FATHER Jake Linhart

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

12 MAIDEN NAME OF MOTHER Nancy Williams

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nell Walker

(Address) Duncans Bridge Mo

15 Filed 1/28 1917 Fred Wielding Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan (Month) 27 (Day) 1917 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jany 25 1917 to Jan 27 1917 that I last saw her alive on Jany 27 1917 and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis 81

77

(Duration) Don't Know yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

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

(Signed) G Braund M. D.

Jany 28 1917 (Address) Duncans Bridge Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 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 .....

19 PLACE OF BURIAL OR REMOVAL Madison Mo

DATE OF BURIAL 1/28 1917

20 UNDERTAKER Fred A. Thompson

ADDRESS Madison Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 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 oc
hospital or p
give its NAM
of street and

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH
..... (Month) ..... (Day), 1..... (Year)

7 AGE
.....yrs. .....mos. .....ds.

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

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

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
..... (Month) ..... (Day), 19..

17 I HEREBY CERTIFY, that I attended decea
....., 191....., to .....,
that I last saw h.....alive on .....,
and that death occurred, on the date stated above, at .....
The CAUSE OF DEATH* was as follows:

.....
.....
.....
..... (Duration) .....yrs. .....mos.

CONTRIBUTORY .....
(Secondary)
..... (Duration) .....yrs. .....mos.

(Signed) .....
....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent C
(1) Means of Injury; and (2) whether Accidental, Suicidal or

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, T
or Recent Residents)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....m

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BUR

20 UNDERTAKER	ADDRESS

Revised United States Standard Certificate of Death

"Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite);