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: Andrew

Township or Village or City: Independence / ~~Parnell Mo~~

Registration District No. 626 — No. 11521

Primary Registration District No. 5828 — Registered No. 21

(NO. ____ St.: ____ Ward)

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

FULL NAME Elizabeth Jane Fowzey

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

~~SINGLE~~ ~~MARRIED~~ WIDOWED ~~OR DIVORCED~~ (Write the word): Widow

DATE OF BIRTH: Sept 1, 1839 (Month) (Day) (Year)

AGE: 77 yrs. 5 mos. 6 ds. — If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmers Wife
(b) General nature of industry, business, or establishment in which employed (or employer): ____

BIRTHPLACE (City or town, State or foreign country): Fayette Co Indiana

PARENTS
- NAME OF FATHER: William Logan
- BIRTHPLACE OF FATHER (City or town, State or foreign country): Indiana
- MAIDEN NAME OF MOTHER: Hattie Cora Heizer
- BIRTHPLACE OF MOTHER (City or town, State or foreign country): Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. T. Logan, Brother

(ADDRESS) Parnell Mo

Filed Mar. 2, 1917. Hiriam Day, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Mar 1, 1917 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 18, 1916, to Mar 1, 1917, that I last saw her alive on Feb 28, 1917, and that death occurred, on the date stated above, at 2:20 a.m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

1.3 B

104.A

(Duration) ____ yrs. ____ mos. 8 ds.

Contributory (Secondary): Cold

(Duration) ____ yrs. 2 mos. 10 ds.

(Signed) E. Crowson M. D.

Mar 2, 1917 (Address) Parnell 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	DATE OF BURIAL
Gayano City Cemetery	Mar 2, 1917
UNDERTAKER	**ADDRESS**
Roy Tatom	Parnell Mo

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

PLACE OF DEATH [redacted]

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