PLACE OF DEATH

County Lawrence

Township ____ or Village ____ or City Pierce (NO. ____ St.: ____ Ward)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 5637

Registration District No. 471 File No. 2

Primary Registration District No. 6284 Registered No. 19

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

FULL NAME Elica Sheyork

PERSONAL AND STATISTICAL PARTICULARS

SEX: female

COLOR OR RACE: White

~~SINGLE~~ ~~MARRIED~~ WIDOWED ~~OR DIVORCED~~ (Write the word) Wid

DATE OF BIRTH: May (Month) 6 (Day), 1844 (Year)

AGE: 73 yrs. 11 mos. 24 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): —

BIRTHPLACE (City or town, State or foreign country): Ohio

PARENTS
NAME OF FATHER: D Phielen
BIRTHPLACE OF FATHER (City or town, State or foreign country): Germany
MAIDEN NAME OF MOTHER: dont Know
BIRTHPLACE OF MOTHER (City or town, State or foreign country): dont Know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas Sheyork

(ADDRESS) Pierce City Mo

Filed 7/8, 1918. J E Barnhill REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Feb (Month) 7 (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from Mch 1, 1917, to Feb 7, 1918, that I last saw her alive on Jan 16, 1918, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

93C 79 (Duration) years ____ mos. ____ ds.

Contributory (SECONDARY) ____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J E Barnhill M. D.

8/9, 1918 (Address) Pierce City 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: Pierce City Mo

DATE OF BURIAL: Feb 10 1918

UNDERTAKER: John Seufert

ADDRESS: Pierce City Mo

MISSOURI STATE BOA
BUREAU OF VITAL S
CERTIFICATE OF D

PLACE OF DEATH

County.....

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

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

Primary Registration District No. ..... Registered No. .....

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 D

DATE OF DEATH

..... (Month)

I HEREBY CERTIFY, that I at

....., 191...., to .....

that I last saw h..... alive on .....

and that death occurred, on the date stat

The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

Contributory .....
(SECONDARY)

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

(Signed) .....

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

*State the Disease Causing Death, or, in dea
(1) Means of Injury; and (2) whether Accidental, Su

LENGTH OF RESIDENCE (FOR HOSPITALS, RECENT RESIDENTS).

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

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

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL

UNDERTAKER.