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

PLACE OF DEATH

County: Andrews

Township: ~~Independence~~ Registration District No. 626 File No. 2-9970

or

Village: Primary Registration District No. 4376 Registered No.

or

City: Pamell Mo (NO. St.; Ward)

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

FULL NAME Elnora Paxton

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	~~SINGLE~~ MARRIED ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word)
Female	White	Married

DATE OF BIRTH: Dec 27 (Month) (Day), 1852 (Year)

AGE: 65 yrs. 2 mos. 27 ds. If LESS than 1 day, hrs. or min.?

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

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

PARENTS

NAME OF FATHER: Thomas Arnold

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

MAIDEN NAME OF MOTHER: Rebecca McGraw

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E A McKin

(ADDRESS) Dalas Iowa

Filed March 25 1918. Hiram Doc
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: March 22 (Month) (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from March 18, 1918, to March 22, 1918, that I last saw her alive on March 22, 1918, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
10 d
(Duration) yrs. mos. ds.

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

(Signed) L O Nye M. D.
Mch 22, 1918 (Address) Pamell 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: Oxford Mo

DATE OF BURIAL: , 191

UNDERTAKER: Roy LaFaun

ADDRESS: Pamell Mo

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTI
BUREAU OF VITAL STATISTICS
CERTIFICATE 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 hospital or institution give its NAME instea 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 fron

....., 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, stat (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, O 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