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

County: Audrain

Township or Village or City: Prairie / Laddonia Mo

Registration District No. 24 — File No. 12029

Primary Registration District No. 4018 — Registered No.

(NO. ____ St.: ____ Ward)

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

FULL NAME: Mrs Ellen Gertrude Ohearn

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female — COLOR OR RACE: White — SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): married

DATE OF BIRTH: Aug (Month) 26 (Day), 1862 (Year)

AGE: 55 yrs. 7 mos. 8 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): House wife

BIRTHPLACE (City or town, State or foreign country): Shipman Ills

PARENTS
NAME OF FATHER: Dont Know
BIRTHPLACE OF FATHER (City or town, State or foreign country): Dont Know
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) J. W. Ohearn

(ADDRESS) Laddonia Mo

Filed April 4, 1918 W. K. McCall REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: April (Month) 3rd (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 8, 1918, to Apr 3, 1918, that I last saw her alive on Mar 29, 1918, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

23A

(Duration) 5 yrs. 28 mos. ____ ds.

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

(Signed) W. K. McCall M. D.

Apr 4, 1918 (Address) Laddonia 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 18 yrs. ____ mos. ____ ds. In the State 49 yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? Place of Death

Former or usual residence ____

PLACE OF BURIAL OR REMOVAL: Laddonia Mo — DATE OF BURIAL: April 6, 1918

UNDERTAKER: W H McCoy — ADDRESS: Laddonia Mo

MISSOURI STATE BOARD OF HEA[illegible]
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

....., 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

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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