LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

Crane

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

39180

1 PLACE OF DEATH

County Greene

Township ..... Registration District No. 318 File No. .....

or

Village ..... Primary Registration District No. 2001 Registered No. 836

or

City Springfield Mo (NO. Springfield Hospital St. Ward)

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

2 FULL NAME Mrs. Elsie O'Bryen

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 Nov. 22 (Month) (Day) 1898 (Year)

7 AGE 20 yrs. ..... mos. 21 ds. If LESS than 1 day, ... hrs. or ..... min.?

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

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

PARENTS

10 NAME OF FATHER James S. Waddell

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

12 MAIDEN NAME OF MOTHER Grace Wicks

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. J. S. Waddell

(Address) 855 Evans St.

15 Filed NOV 13 1918 191 Edwin F. James Registrar
Dollie B. Johnson Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 12 (Month) (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov. 10, 1918 to Nov. 12, 1918, that I last saw her alive on Nov. 12, 1918, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Peritonitis

Possible (Duration) 4 or 6 days yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) not definitely known (Duration) Possibly 6 months yrs. ..... mos. ..... ds.

(Signed) T. V. B. Crane M. D.

Nov. 13, 1918 (Address) #318 College

*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 East Lawn

DATE OF BURIAL 11-14-1918

20 UNDERTAKER [illegible]

ADDRESS [illegible] Market

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEAI
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 occu
hospital or in
give its NAME
of street and n

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 deceas

....., 191....., to....., 1

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 Ca
(1) Means of Injury; and (2) whether Accidental, Suicidal or H

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

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

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

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL

20 UNDERTAKER	ADDRESS