LOCAL REGISTRAR'S RECORD DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH Noel Mo
County McDonald
Township Elk River
Village Noel
City ..... (No. ..... St. ..... Ward)

Registration District No. 1149 Primary Registration District No. 0696
File No. 33624 B
Registered No. .....

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

2 FULL NAME Minnie Maxine Elledge

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Single

6 DATE OF BIRTH Dec (Month) 11 (Day) 1912 (Year)

7 AGE 6 yrs. 10 mos. 26 ds. — If LESS than 1 day, ... hrs. or ..... min.?

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

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

10 NAME OF FATHER Charles Wesley Elledge

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Bentonville Ark

12 MAIDEN NAME OF MOTHER Ethel B. Sanders

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) South West City Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas W. Elledge
(Address) Noel Mo

Filed Nov 7, 1919. O. S. John Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov (Month) 6 (Day), 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 30, 1919, to Nov 6, 1919, that I last saw her alive on Nov 6, 1919, and that death occurred, on the date stated above, at 8 15 a.m.

The CAUSE OF DEATH* was as follows:
General Peritonitis
126 173 P
(Duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Constipation
(Duration) 1 yrs. 6 mos. ..... ds.

(Signed) J. B. F. Rogers M. D.
Nov 11, 1919 (Address) Noel Mo

*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 South West City Mo

19 PLACE OF BURIAL OR REMOVAL South West City Mo — DATE OF BURIAL Nov 7, 1919

20 UNDERTAKER Deere — ADDRESS Sulphur Springs Ark

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEA
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 occur
hospital or inst
give its NAME
of street and nu

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

....., 1.....
(Month) (Day) (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

....., 191..
(Month) (Day) (

17 I HEREBY CERTIFY, that I attended deceased

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

that I last saw h.....alive on ....., 191

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) ..... M

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

*State the Disease Causing Death, or, in deaths from Violent Causes (1) Means of Injury; and (2) whether Accidental, Suicidal or Homic

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transie 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
	....., 191

20 UNDERTAKER	ADDRESS