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: Scott

Township: ~~Morley~~

or Village: Morley

or City: ____ (No. ____, ____ St.; ____ Ward)

Registration District No. 819 — File No. 34937

Primary Registration District No. 4495 — Registered No. 14

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

FULL NAME Estella Georgia Elmore

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: December (Month) 16 (Day), 1886 (Year)

AGE: 32 yrs. 11 mos. 9 ds. — If LESS than 1 day, ____ hrs. or ____ min.?

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

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

PARENTS
NAME OF FATHER: M. V. Harris
BIRTHPLACE OF FATHER (City or town, State or foreign country): Tenn.
MAIDEN NAME OF MOTHER: Martha E. Brown
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Tenn.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE —
(Informant) Arnold Franklin
(ADDRESS) Vandusen, Mo.

Filed Dec 8, 1919 Mrs Nell Tomlinson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: November (Month) 25 (Day), 1919 (Year)

I HEREBY CERTIFY, that I attended deceased from Nov. 9, 1919, to Nov. 25, 1919, that I last saw her alive on Nov 24, 1919, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:
Puerperal Septicemia

145A 137

(Duration) ____ yrs. ____ mos. 18 ds.

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

(Signed) Arnold Franklin M. D.
Nov. 25, 1919 (Address) Vandusen, 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: Morley Cem.
DATE OF BURIAL: Nov 26, 1919
UNDERTAKER: C. D. M. Gupton
ADDRESS: Morley Mo

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.....

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