

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

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.

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

MARGIN RESERVED FOR BINDING

PLACE OF DEATH
nty Wright
nship Mountain Gem
age Mountain Gem (NO. _____ St.: _____ Ward _____)

Registration District No. 908File No. 28589Primary Registration District No. 4549Registered No. 101FULL NAME Elias Alexandria Belue

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

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED married WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH mar 24 1872 (Month) (Day) (Year)
AGE 79 yrs. 4 mos. 22 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION farming General nature of industry, trade, profession, or particular kind of work
General nature of business, or establishment in which employed (or employer)

PLACE OF BIRTH Montgomery Alabama (City or town, State or foreign country)

NAME OF FATHER Hosea Belue

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

MAIDEN NAME OF MOTHER Matilda Sturgeon

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

ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Signature Mrs. Dora Gress

(ADDRESS) Mountain Gem

8/16 20 JM Hubbard

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Aug 16 1920 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 4 1920 to Aug 16 1920
that I last saw him alive on Aug 15 1920
and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

Renal edema following acute gastritis and cardiac asthma

(Duration) 96 yrs. 2 mos. 12 ds.

Contributory acute gastritis from type 2 trouble

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

(Signed) JM Hubbard M. D.

8/16 1920 (Address) Mountain Gem

*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 Ozak Creek La Grange

DATE OF BURIAL 8/17 1920

UNDERTAKER N L Belue

ADDRESS Mountain Gem

PLACE OF DEATH

County _____
 Township _____
 or _____
 Village _____
 or _____
 City _____

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

City _____ (NO _____ St. _____ Ward _____)

(If death occurred
 hospital or insti-
 tute, give its NAME
 of street and number)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (If write the word)
DATE OF BIRTH	(Month) _____ (Day) _____ (Year) _____	
AGE	(Month) _____ (Day) _____ (Year) _____	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) _____

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 _____

(Month) _____ (Day) _____

I HEREBY CERTIFY, that I attended deceased _____, 191____, to _____, 19____,

that I last saw him alive on _____, 19____,

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) _____

(Address) _____

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos.

Where was disease contracted if not at place of death?

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____

DATE OF BURIAL _____

UNDERTAKER _____

ADDRESS _____

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

MARGIN RESERVED FOR BINDING

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