LOCAL REGISTRAR'S RECORD—DO NOT TEAR/LEAF OUT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

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

1 PLACE OF DEATH

County Marion

Township Warren — Registration District No. 5-5-2 — File No. 100 77 a

or

Village — Primary Registration District No. 5745 — Registered No.

or

City (NO. , St. Ward)

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

2 FULL NAME Sariah J. McElroy

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: Aug (Month) 11 (Day) 1849 (Year)

7 AGE: 71 yrs. 8 mos. 11 ds. — If LESS than 1 day, hrs. or min.?

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

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

10 NAME OF FATHER: Wm C Mithell

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Va

12 MAIDEN NAME OF MOTHER: Alice T Bell

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Va

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W C McElroy

(Address) Emden Mo

Filed Apr 16 1921 Mrs Lee Davis Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Apr (Month) 14 (Day) 1921 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Feb 26 1921, to Apr 14 1921, that I last saw her alive on Apr 14 1921, and that death occurred, on the date stated above, at 8 15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Tuberculosis
Bronchial Pneumonia
of 20 days

(Duration) 31 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pleurisy with Effusion (Duration) about 1 yrs. 40 mos. ds.

(Signed) Gregory Delaney M. D.

Apr 15 1921 (Address) Emden

*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: Andrew Chappel — DATE OF BURIAL: Apr 17 1921

20 UNDERTAKER: J. W. Thompson & Co — ADDRESS: Hunnewell Mo.

LOCAL | NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
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 occurred in a hospital or institution, give its NAME instead of street and number.]

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) ....., 191..... (Year)

17 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.

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

DATE OF BURIAL
..... 191.....

20 UNDERTAKER

ADDRESS