

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

28200

1. PLACE OF DEATH

County Cass Registration District No. 154 File No. _____
 Township _____ Primary Registration District No. 4688 Registered No. _____
 City Warren, Mo. (No. _____) St. _____ Ward _____

2. FULL NAME

Elizabeth McCulloh
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR widowed (write the word)
 5A. IF MARRIED, WIDOWED, OR DIVORCED Married (OR) WIFE OF Arch S. McCulloh
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 19 - 1873
 7. AGE YEARS 77 MONTHS 2 DAYS 12 If LESS than 1 day, _____ hrs. or _____ min.
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housekeeper
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Penn

10. NAME OF FATHER

Jacob Zimmerman

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Penn

12. MAIDEN NAME OF MOTHER

Catharine Seehrist

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Penn

14. INFORMANT

J. M. M. McCulloh
 (Address) Warren City, Mo.

15. FILED

Oct 1 - 1922 F B Ellis
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct - 1 - 1922
 17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on Oct - 1 - 1922, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis of Lungs,
L3A

CONTRIBUTORY (SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

0 DID AN OPERATION PRECEDE DEATH? NO DATE OF _____

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Frank B Ellis, M. D.
 , 19 (Address) Warren City, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Dayton Cemetery DATE OF BURIAL Oct 3 1922

20. UNDERTAKER

J M Kauffman ADDRESS Warren City

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

