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 INDELIBLE INK—THIS IS A PERMANENT RECORD

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

PLACE OF DEATH

County: Rodgeway

Township: Washington
or
Village:
or
City: (NO. , St.: Ward)

Registration District No. 623 — File No. 27811

Primary Registration District No. 5825 — Registered No.

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

FULL NAME Elizabeth Hagan

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

~~SINGLE~~ ~~MARRIED~~ WIDOWED ~~OR DIVORCED~~ (Write the word): W

DATE OF BIRTH: Aug (Month) 21 (Day), 1835 (Year)

AGE: 88 yrs. mos. 10 ds.

If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): —

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

PARENTS
NAME OF FATHER: Robert Stewart
BIRTHPLACE OF FATHER (City or town, State or foreign country): Indiana
MAIDEN NAME OF MOTHER: Elizabeth Stewart
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Dont Know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Samuel Hagan

(ADDRESS): Bannister Mo

Filed Sept. 2, 1923 J. M. McClanahan
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Sept (Month) 1 (Day), 1923 (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 28, 1913, to Sept 1, 1923, that I last saw her alive on Aug 30, 1923, and that death occurred, on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Paralysis

82 D

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) M. McCallard M. D.

Sept 2, 1923 (Address) Bannister 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: Gentland Mo

DATE OF BURIAL: Sept 2, 1923

UNDERTAKER: Chas Reynolds

ADDRESS: Gentland Mo

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 .....

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.

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

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