LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

6767

PLACE OF DEATH
County Bates — Registration District No. 50 — File No.
Township Mt. Pleasant — Primary Registration District No. 5074 — Registered No. 207
City (No. St. Ward)

FULL NAME Ellen Conlia Willard

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
th 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

X	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	W	widow

MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

TE OF BIRTH (MONTH, DAY AND YEAR) Jan. 19th 1837

E	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	87	1	27	3

CUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Housekeeper
(c) Name of employer

RTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) New York

. NAME OF FATHER J. F. Estrander

. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) New York

. MAIDEN NAME OF MOTHER Rowena Wells

. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Penn.

NFORMANT Frances Willard
Address) Butler Mo

ILED Apr. 10th 1924 G. F. Lockwood
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 16th 1924

17.
I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19.... that I last saw h..... alive on ....., 19...., and that death occurred, on the date stated above, at 10 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
No physician was in attendance
She died rather suddenly
She must have died from apoplexy
As she had been paralyzed for
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Three years from an attack of apoplexy
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED I viewed the body
IF NOT AT PLACE OF DEATH? after death
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? History of case
(Signed) G. F. Lockwood, M. D
, 19 (Address) Butler 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	DATE OF BURIAL
Oak Hill	Mar. 20th 1924
20. UNDERTAKER	ADDRESS
Culvers	Butler

V. S. No. 2.

MARGIN RESERVED FOR BINDING

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.

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CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No.....,..... St. .....W

2. FULL NAME .....

(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(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)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

17.
I HEREBY CERTIFY, That I attended deceased from .....
.....,19....., to .....,
that I last saw h..... alive on.....,19.....,
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, (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 | DATE OF BURI

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