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.

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

File No. 28136

**PLACE OF DEATH**

County: Andrew

Township: Platte

or Village:

or City: (NO. St.; Ward)

Registration District No.: 15

Primary Registration District No.: 5019

Registered No.: 12

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

**FULL NAME** Lizzie Clark

**PERSONAL AND STATISTICAL PARTICULARS**

SEX: Female

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: April 29 (Month) (Day), 1861 (Year)

AGE: 63 yrs. 5 mos. 16 ds.

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

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

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

PARENTS

NAME OF FATHER: John Sherman

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

MAIDEN NAME OF MOTHER: Mary Sattler

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): J. C. Clark

(ADDRESS): Rea Mo

Filed: Oct 15, 1924 E C Jeffries REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH: Oct 15 (Month) (Day), 1924 (Year)

I HEREBY CERTIFY, that I attended deceased from Jany, 1924, to Oct 15, 1924, that I last saw her alive on Oct 15, 1924, and that death occurred, on the date stated above, at 3 30 a.m.

The CAUSE OF DEATH* was as follows:

Huntingdon's Chorea

8 YB

(Duration) 4 yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) E C Jeffries M. D.

Oct 15 1924 (Address) Whitesville

*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: Savannah

DATE OF BURIAL: Oct 16 1924

UNDERTAKER: W. L. Cole

ADDRESS: King City

# 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** _____

**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

_____ (Month) _____ (Day), 191__ (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 |

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

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