

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

22931

1. PLACE OF DEATH
 County KIRKSVILLE MO ADAIR Registration District No. 4 File No. _____
 Township _____ Primary Registration District No. 3001 Registered No. 142
 City KIRKSVILLE MO (No. _____) St. _____ Ward _____

2. FULL NAME EMMA I MINNICK
 (a) Residence No. 1108 S FLORANCE ST 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 DIVORCED (write the word) SINGLE

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) SEPT 10 1863

7. AGE YEARS MONTHS DAYS 61 II If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work NURSE
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer PUBLICOCK

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) FLORIST IOWA
FLORIST IOWA

10. NAME OF FATHER DAVID MINNICK

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

12. MAIDEN NAME OF MOTHER ELIZABETH A ATTERBURY

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

14. INFORMANT Mrs Ward
 (Address) KIRKSVILLE MO

15. FILE NO. 8 31. 19. 25 AWP
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8 26 19 25

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

THE CAUSE OF DEATH WAS AS FOLLOWS:
By breathing artificial Gas with suicidal intent found in their house dead
11-1-6 (duration) _____ yrs. _____ mos. _____ ds.

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

18. WHERE WAS DISEASE CONTRACTED _____ IF NOT AT PLACE OF DEATH: _____

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

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) F. P. Easley, Coroner
1925 (Address) Brookman, 2200

*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 HIGHLAND PARK DATE OF BURIAL Aug 29 19 25

20. UNDERTAKER Robert H. Wilson Kirksville
 ADDRESS _____

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.

