

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

Do not use this space.

17921

1. PLACE OF DEATH

County Douglas
Township Spencer
City

Registration District No. 1075
Primary Registration District No. 3381

File No.
Registered No. 3
St. Ward

2. FULL NAME

Heberah Purvis

(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 DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 20 1842

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
85 1

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) Illinois

10. NAME OF FATHER

John William

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Indiana

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT R. W. Swearingin
(Address) Box 5, RR. 5

15.

FILE 420-27 J. E. Hale

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 20 1927

17. I HEREBY CERTIFY, That I attended deceased from 1927, to 1927, that I last saw h. alive on 6-13-27, and that death occurred, on the date stated above, at 1215 A.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Alcoholic poisoning
13913
12012

CONTRIBUTORY (SECONDARY)

Alcohol Intoxication
(duration) yrs. mos. 8 ds.

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) J. R. H. Williams, M.D.
6-22-1927 (Address) Franklin, 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Easter Cemetery 6-22 1927

20. UNDERTAKER

ADDRESS

L. R. Watson, Supt. 2020,

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.

JUL 26 1927

125

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Armenia

Was the ~~Ptolemies~~
poisoning from
food or from
~~kidneys~~
something else?

(?) Thanks (?)

55 (2) 17921

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Lyon glass
Township Speyerer
City (No.)

Registration District No. 1075-
Primary Registration District No. 5381

File No.
Registered No. 3
St. Ward

2. FULL NAME

Lebanah Burris

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

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. 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)

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 6/20 27 Ho. Hale

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 20 1927

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:

Cholera Morbus
CONTRIBUTORY (SECONDARY) 6 ds.

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) S. O. H. Williams, M. D.
9-13-27 (Address) Franklin, 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

AGE shall be stated EXACTLY
classified
CATEGORIES UNTIL THEY ARE COMPLETED
REGISTRARS

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