

11 28 1927

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

Do not use this space.

18890

1. PLACE OF DEATH

County Mason
Township Mason
City Hannibal (No.)

Registration District No. 547
Primary Registration District No. 3039

File No.
Registered No. 186
St. H. Elizabeth Hospital Ward

2. FULL NAME

Elizabeth Stevenson
(a) Residence. No. Warren Mo St. Ward. Warren Mo
(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

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

6-3-1863

7. AGE

YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
59 22

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Warren Mo

(STATE OR COUNTRY)

10. NAME OF FATHER

Thomas Stevenson

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Mason County

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Jannetta McAluse

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Kentucky

(STATE OR COUNTRY)

14.

INFORMANT

(Address) Ben Allen
Philadelphia Mo

15.

FILED 17 1927

W. E. Stock
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

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

6-7-27 - 1927

17.

I HEREBY CERTIFY, That I attended deceased from Jan 27, 1927 to June 25, 1927 that I last saw h. her alive on June 25, 1927, and that death occurred, on the date stated above, at 6 P m.

THE CAUSE OF DEATH** WAS AS FOLLOWS:

Hemorrhage from bladder

1357
52.8

CONTRIBUTORY (SECONDARY)

Carcinoma (?) bladder
(duration) yrs. mos. ds. 4

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH,

1 DID AN OPERATION PRECEDE DEATH.

yes DATE OF 6-8-27

WAS THERE AN AUTOPSY?

no

WHAT TEST CONFIRMED DIAGNOSIS.

(Signed) J. H. Hurd, M. D.
, 19 (Address) Hannibal 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

Andrew Chapel

19

20. UNDERTAKER

ADDRESS

James O'Donnell

Hannibal Mo

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**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Marion Registration District No. 547 File No.
Township Warren Primary Registration District No. 3029 Registered No. 186
City Warren St. Ward)

2. FULL NAME

(a) Residence No. 9 Warren, Mo 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 3, 1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
X 64 22

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 6/27 1927 W. H. Shott

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 25 1927

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. 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)....., M. D. , 19 (Address)

*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

19

20. UNDERTAKER ADDRESS

N. B.—Every item of information 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-18890