AUG 19 1927

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

20384

1. PLACE OF DEATH
County: Stoddard — Registration District No.: 834 — File No.:
Township: Pike — Primary Registration District No.: 6097 — Registered No.: 22
City: (No. , St. Ward)

2. FULL NAME: Eliza Jane Hinson

(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): Widow

6. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF: Widow of Wm Hinson

DATE OF BIRTH (MONTH, DAY AND YEAR): Apr 1st 1842

AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	85	2	10	

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

BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Tenn

10. NAME OF FATHER: Robt. Cates

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Don't Know

12. MAIDEN NAME OF MOTHER: Tallie Kelley

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Don't Know

INFORMANT: John Gibson
(Address): Bloomfield Mo R.2

FILED 7-13 1927 N. McKearly REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): June 11th 1927

17. I HEREBY CERTIFY, That I attended deceased from Apr. 3rd 1927, to June 11th 1927, that I last saw her alive on June 7th 1927, and that death occurred, on the date stated above, at 8:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Dropsy
12-13

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (SECONDARY): Cirrhosis of Liver
(duration) 2 yrs. mos. ds.

12201

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH:
DID AN OPERATION PRECEDE DEATH? no DATE OF:
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS? —
(Signed) S. S. Davis, M. D.
7-12, 1927 (Address) Bloomfield, 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: Gravel Hill Cemetery Mo. — DATE OF BURIAL: 6/12 1927
20. UNDERTAKER: Jas A. Chiles — ADDRESS: Bloomfield Mo.

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MISSOURI STATE BOARD OF HEALTH
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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. .....Ward

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. d

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) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
.....,19....., to ....., 19.
that I last saw h..... alive on....., 19....., an
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, SUICID HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BUR
20. UNDERTAKER	ADDRESS