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

Do not use this space.

File No. 21695

Registered No.

1927 AUG

1. PLACE OF DEATH
County: Jasper
Township:
City: Carthage (No. , St. Ward)

Registration District No. 408
Primary Registration District No. 3020

2. FULL NAME Mrs. Emma Conway

(a) Residence. No. 817 S. Camron 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 11 - 1863

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	64	4	23	

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

9. BIRTHPLACE (CITY OR TOWN) Illinois
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER C. C. Bizzer
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Cotton Co.
(STATE OR COUNTRY) Ky.
12. MAIDEN NAME OF MOTHER Dathula Hoffman
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Campbell Co.
(STATE OR COUNTRY) Ky.

14. INFORMANT Mr. Jno. Conway
(Address) Carthage, Mo.

15. FILED July 5, 1927 S. B. Christy
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 4th 1927.

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1927, to July 4, 1927, that I last saw h. alive on July 2, 1927, and that death occurred, on the date stated above, at 2:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Intestinal Tuberculosis 25 (duration) 2 yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? Yes
DID AN OPERATION PRECEDE DEATH? No Date of
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? None
(Signed) Warren D. Chapman, 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 New Hope Cemetery — DATE OF BURIAL 7/5/1927

20. UNDERTAKER Kneel Mortuary — ADDRESS Carthage

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.