AUG 17 1927

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

Do not use this space.

21883

1. PLACE OF DEATH

County Linn — Registration District No. 496 — File No.

Township — Primary Registration District No. 3025 — Registered No. 54

City Brookfield (No. ..... St. ..... Ward)

2. FULL NAME Elmer R. Lear.

(a) Residence. No. 924 - Strawbridge St., 2 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Anna-Mary Lear

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 1-18-1854

7. AGE: 73 YEARS, 5 MONTHS, 29 DAYS — If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN): Bethel -
(STATE OR COUNTRY): Shelby - Co. Mo.

PARENTS

10. NAME OF FATHER: Tom. Lear -
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Not Known -
(STATE OR COUNTRY): Kentucky
12. MAIDEN NAME OF MOTHER: Garelda Hayden
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Not Known
(STATE OR COUNTRY): Not known

14. INFORMANT: Elmer Streator -
(Address): 924 - Strawbridge St

15. FILED 7-18, 1927 Bessie M. Fox Deputy. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 7-17-1927

17. I HEREBY CERTIFY, That I attended deceased from 5-16, 1926, to 7-17, 1927 that I last saw him alive on 7-17, 1927, and that death occurred, on the date stated above, at 4:30 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Q 151

Chronic Intestinal Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? No. DATE OF No

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Test

(Signed) Jno. M. Lang, M. D

19 (Address) Brookfield 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: Palmyra Mo — DATE OF BURIAL: 7-19 1927

20. UNDERTAKER: C. W. Hill — ADDRESS: Brookfield 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.