

AUG 17 1927

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

Do not use this space.

121959

1. PLACE OF DEATH

County Marion
Township Marion
City Harrisonville (No. W.P.O.)

Registration District No. 547
Primary Registration District No. 3039
Broadway

File No. _____
Registered No. 218
St. 6 (Ward)

2. FULL NAME

Elysa Plonnelly
J. D. Donnell

(a) Residence, No. 2300 W. Broadway St.
(Usual place of abode)

Ward.

(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 Willis Plonnelly

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Not known

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
about 75 no record

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER no record

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) No Record

12. MAIDEN NAME OF MOTHER no Record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Not known

14. INFORMANT Mrs. Ellen Bell
(Address) 1210 North St.

15. FILED 8/2 1927
C. E. Stode
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 27 1927

17. 7:30 PM

HEREBY CERTIFY That I attended deceased from Nov 26, 1926 to July 27, 1927 that I last saw him alive on July 27, 1927, and that death occurred, on the date stated above, at 7:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocardial Insufficiency
92A
13 mo. (duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED 900A
AT PLACE OF DEATH

4. DID AN OPERATION PRECEDE DEATH? DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) H. Plonnelly, M. D.
7/28/27 (Address) 1217 Ch...

*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 Robinson Cem
DATE OF BURIAL 8/1 1927

20. UNDERTAKER Geo E Roberts
ADDRESS _____

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.

RECORD

It should be stated that EXAC
has been formed

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**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
Towship.....
City Hannibal (No.)

Registration District No. 347
Primary Registration District No. 3829

File No.
Registered No. 218
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. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>B</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>wid</u>
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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.
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8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
(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 8/27, 19 27 606 Stroll

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 27 19 27

17. I HEREBY CERTIFY That I attended deceased from 19....., 19....., that I last saw h..... alive 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

Geo E Roberts

ADDRESS

Hannibal

N. B.—Every item of information should be carefully supplied. AG 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

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