AUG 7 1927

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

Do not use this space.

21979

1. PLACE OF DEATH

County: Marion — Registration District No. 5-48 — File No.

Township: Liberty — Primary Registration District No. ~~[illegible]~~ — Registered No. 29

City ..... (No. ..... 5740 ..... St. ..... Ward)

2. FULL NAME Mary Elizabeth Lear

(a) Residence. No. County Infirmary, ... 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 W. H. Lear

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7/28-1847

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
79	11	29	

8. 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

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Loudan Co Va.

PARENTS

10. NAME OF FATHER Addison Stillson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Loudan Co. Va.

12. MAIDEN NAME OF MOTHER Susan Gibson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Loudan Co Va

14. INFORMANT F M Stillson
(Address) Palmyra Mo R.F.D.

15. FILED 7/28, 1927 S. Sanford
REGISTRAR

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MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Dec. 21, 1926, to July 27, 1927 that I last saw her alive on July 27, 1927, and that death occurred, on the date stated above, at 7 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Exhaustion from haemiplegia (not traumatic)

R.F.D. 17.2. (duration) ..... yrs. 7 mos. 4 ds.

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

750

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

0 DID AN OPERATION PRECEDE DEATH? no DATE OF ✓

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) S. Sanford, M. D

7/28, 1927 (Address) Palmyra 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 7/30 1927

20. UNDERTAKER A M Sprague — ADDRESS Palmyra 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.