

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

Do not use this space.

24342

3120

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township 1st Primary Registration District No. 1007
 City Wrensburg (No. 100) Gen Hosp St. _____ Ward _____

File No. _____
 Registered No. _____

2. FULL NAME

Lizzie Marie Gabriel
 (a) Residence No. 400-N-Bellair St. and _____
 (Usual place of abode) _____ (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. _____ How long in U.S., if of foreign birth? yrs. mos. ds. _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Everett Gabriel

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
Just 29 yrs

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Kans
 (STATE OR COUNTRY) _____

10. NAME OF FATHER Tom Myers

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Okla
 (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Sarah Wylkert

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Kans
 (STATE OR COUNTRY) _____

14. INFORMANT Charles Wylkert
 (Address) Wathena Kans

15. FILED 8/11/27 M.M. Croome REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 11 19 27

17. Carson
 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ 4:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

40 Abortion (Self)
Induced
129 (duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED 14-6
 IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
 (Signed) H.E. Moore, M.D.

8-11-27 (Address) Coroner

*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 Troy Kans DATE OF BURIAL Aug 14 19 27

20. UNDERTAKER Roe & Co ADDRESS 15 Jackson

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.

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