SEP 30 1927

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

Do not use this space.

25196

1. PLACE OF DEATH
County Ralls
Township
City Center Mo (No. ..... St. ..... Ward)
Registration District No. 725
Primary Registration District No. 4431
File No.
Registered No.

2. FULL NAME Elizabeth Kathern Combs.
(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 33 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) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ~~Elizabeth Combs~~ John W Combs

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 20 1845

7. AGE 82 YEARS MONTHS 3 DAYS 23 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife 82 82 97
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

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

PARENTS
10. NAME OF FATHER Chas G. Markel
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Ren
12. MAIDEN NAME OF MOTHER Elizabeth McFarland
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Mo

14. INFORMANT Mabel Glover
(Address) Center Mo

15. FILED Aug 15th, 1927 J. T. Howard REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 11 1927

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927, to Aug 11, 1927, that I last saw her alive on Aug 10, 1927 and that death occurred, on the date stated above, at 3 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Paralysis
Cerebral hemorrhage - left side (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Age - Arteriosclerosis (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
8 DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) H B Norton, M. D
Sept 3, 1927 (Address) Center 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 Salem Cemetry
DATE OF BURIAL Aug 13 1927
20. UNDERTAKER W. H. Couch
ADDRESS Center 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.