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

Do not use this space.

31147

1. PLACE OF DEATH
County: Pettis
Township: ~~La Monte~~
City: La Monte (No. ..... St. ..... Ward)
Registration District No.: 667
Primary Registration District No.: 4400
File No.: [redacted]
Registered No.: .....

2. FULL NAME: Elizabeth Francis Harris
(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 70 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: Geo P. Harris

6. DATE OF BIRTH (MONTH, DAY AND YEAR): [redacted] 31 1851

7. AGE: 75 YEARS, 9 MONTHS, 25 DAYS. If LESS than 1 day, ... hrs. or ..... min.

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): Geo Town
(STATE OR COUNTRY): Missouri

PARENTS
10. NAME OF FATHER: W. D. Shelby
11. BIRTHPLACE OF FATHER (CITY OR TOWN): .....
(STATE OR COUNTRY): Virginia
12. MAIDEN NAME OF MOTHER: Elnor Brown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): .....
(STATE OR COUNTRY): Mo

14. INFORMANT: P. P. Harris
(Address): La Monte Mo.

15. FILED Oct 26 1927 B. F. Parker
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Oct 26 1927

17. I HEREBY CERTIFY, That I attended deceased from June 15, 1925, to Oct 26, 1927, that I last saw her alive on Oct 26, 1927, and that death occurred, on the date stated above, at 9 P. m.

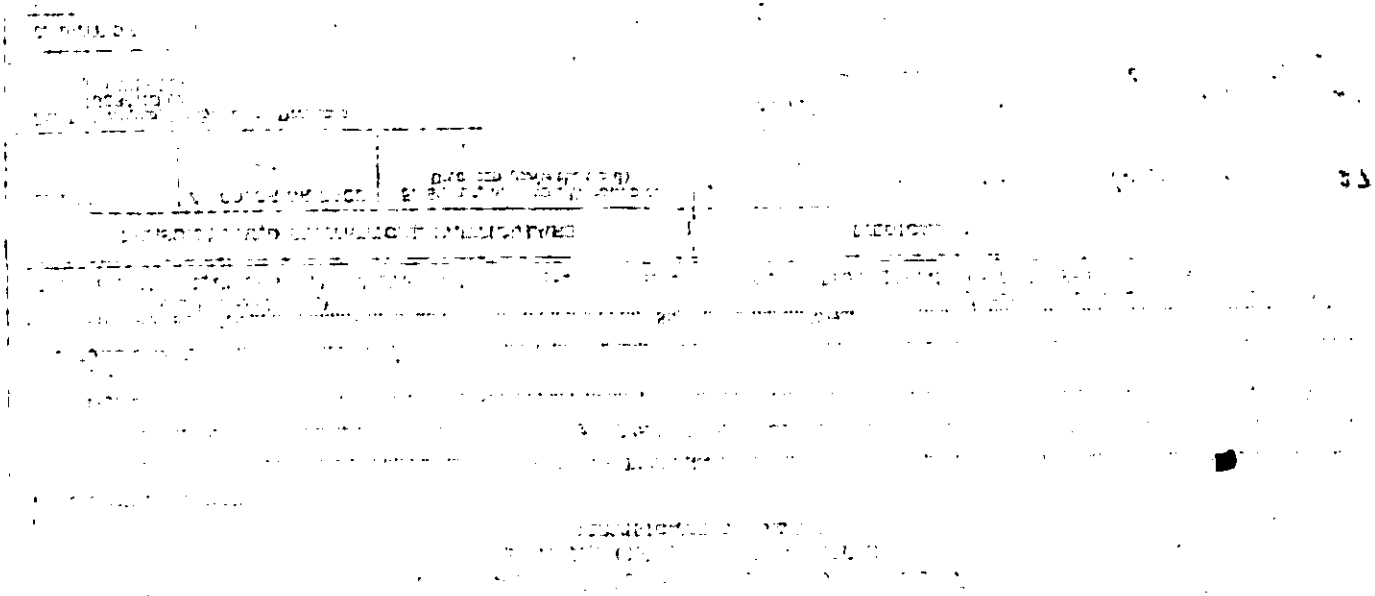
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Interstitial Nephritis
131 1290
(duration) 2 yrs. 4 mos. 11 ds.

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 .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Usual
(Signed) W. E. Walker, M. D
, 19 (Address) La Monte 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: La Monte
DATE OF BURIAL: Oct 28 1927

20. UNDERTAKER: B F Parker
ADDRESS: La Monte 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.