

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

Do not use this space.

1. PLACE OF DEATH
 County Marion Registration District No. 547
 Township Mason Primary Registration District No. 3029
 City Hannibal (No. St. Elizabeth Hospital)
 File No. 34102
 Registered No. 303 St. _____ Ward _____

2. FULL NAME Nora V. Montgomery
 (a) Residence. No. Center 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

6. If MARRIED, WIDOWED, OR DIVORCED
~~XX~~ HUSBAND
~~XX~~ WIFE OF

Andy Montgomery

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 25 1881

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
46 1 19

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) Perry
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Ellis Parks

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

12. MAIDEN NAME OF MOTHER Eliza Chastine

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

14. INFORMANT Andy Montgomery
 (Address) Center No.

15. FILED 11/16/27 O. Stale REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 14 27

17. I HEREBY CERTIFY, That I attended deceased from 10/31/27 to 11/14/27
 that I last saw 11/14/27 alive on 11/14/27 at 9:40 A.M. and that death occurred, on the date stated above, at _____

THE CAUSE OF DEATH WAS AS FOLLOWS:

Hepatitis
126R 136R 136R 136R 136R 136R 136R 136R 136R 136R
136R 136R 136R 136R 136R 136R 136R 136R 136R 136R
 (duration) yrs. 3 mos. da.

CONTRIBUTORY (SECONDARY) 4413
 (duration) yrs. mos. da.

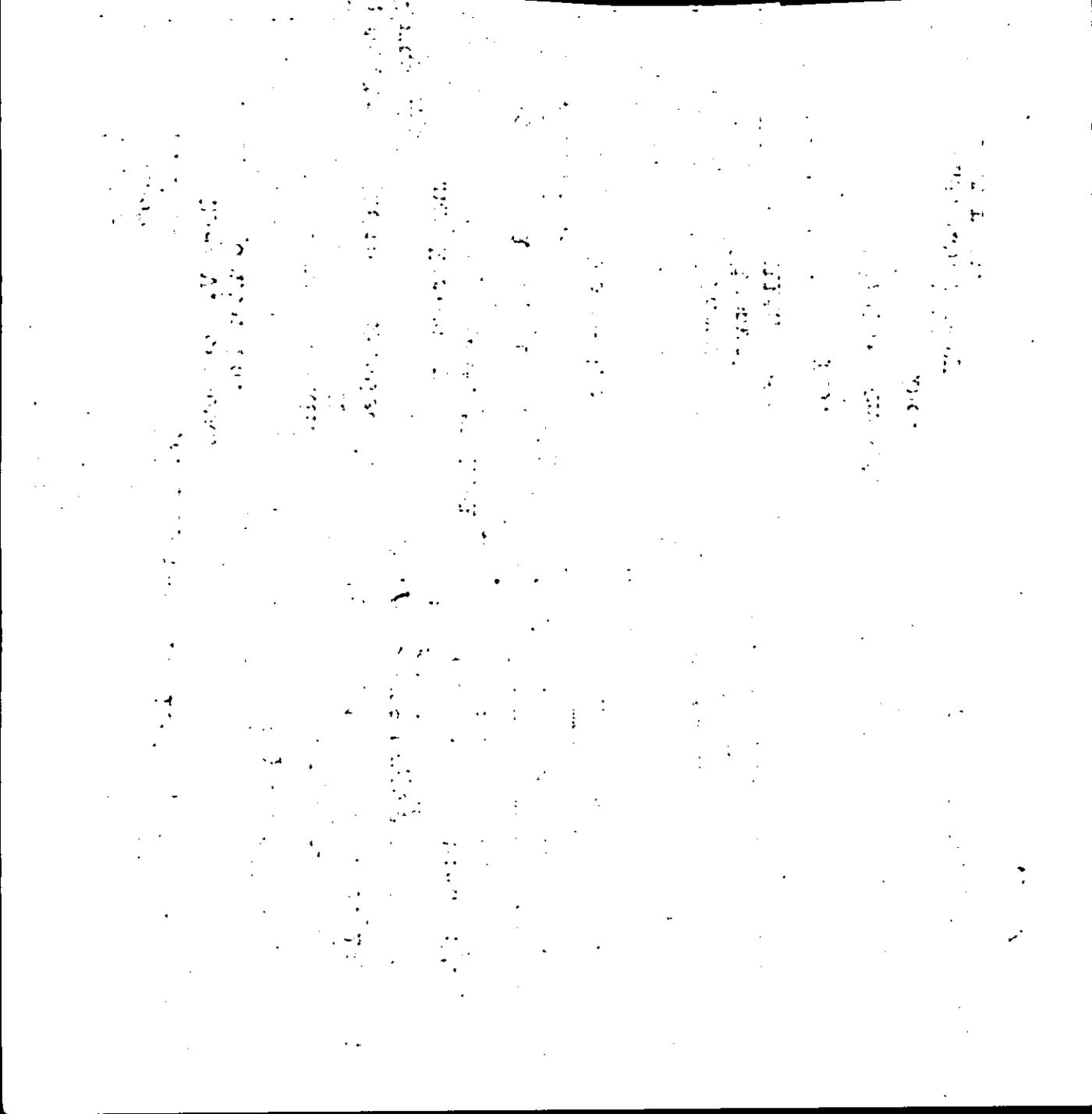
18. WHERE WAS DISEASE CONTRACTED Railroad
 IF NOT AT PLACE OF DEATH? no

DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) J. J. Brown, M.D.
11/16/27 (Address) St. Elizabeth Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MANNER AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL near Perry Missouri DATE OF BURIAL 11 19
Mt. Pleasant Cemetery
 20. UNDERTAKER _____ ADDRESS _____



**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 Registration District No. 347 File No. _____
 Township _____ Primary Registration District No. 3029 Registered No. 303
 City Hannibal (No. _____, St. _____, Ward _____)

2. FULL NAME

Nora V. Montgomery
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

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, _____ hr. or _____ min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work _____
 (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 11/16, 1927 Castro REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 14 1927

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 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. _____ da.

_____ (duration) _____ yrs. _____ mos. _____ da.

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 _____

20. UNDERTAKER _____ ADDRESS _____

N. B.—Every item of information should be carefully submitted. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be verified. AGE should be stated in years, months, and days. Exact classification is important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-34102