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

Do not use this space.

36634

1. PLACE OF DEATH
County Harrison — Registration District No. 340 — File No.
Township Dallis — Primary Registration District No. 5476 — Registered No.
City Martinsville (No. ..... St. ..... Ward)

2. FULL NAME Elizabeth Mock
(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wessley W Mock

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 9 1840

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
87	6	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Keeper
(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) Missouri

PARENTS
10. NAME OF FATHER Vinson Carter
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Tenn
12. MAIDEN NAME OF MOTHER Patients Glendening
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Ohio

14. INFORMANT J R Mock
(Address) New Hampton Mo.

15. FILED Jan 10, 1928 J G Wilson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 24 1927

17. I HEREBY CERTIFY, That I attended deceased from Dec 5, 1927, to Dec 24, 1927, that I last saw her alive on Dec 13, 1927, and that death occurred, on the date stated above, at 6 30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broken Femur + Bronchitis
186 A
194 B
196 C
..... (duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (SECONDARY) .....
..... (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) J G Wilson, M. D
Dec 25, 1927 (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: Kidwell at Martinsville Mo
DATE OF BURIAL: Dec 25 1927

20. UNDERTAKER: W G Noble
ADDRESS: New Hampton 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.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Harrison Registration District No. 340 File No. .....

Township Dallas Primary Registration District No. 5476 Registered No. .....

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Elizabeth Mack

(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. 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)
F	W	Wid

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, ... hrs. 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)

PARENTS

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 Jan 10 1928 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 24 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19....., that I last saw b..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broken Femur &
Bronchitis
Prostrated & a fall
(duration) ..... yrs. ..... mos. ..... ds.

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

185

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 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

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

5-36634