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

Do not use this space.

36647

1. PLACE OF DEATH
County Henry — Registration District No. 14
Township ... — Primary Registration District No. 4211
City Hudson — No. ... St. ... Ward)

File No. ...
Registered No. 40

2. FULL NAME Mrs Elsie E Larson

(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: F
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 W T Larson

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

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40	11	22	

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

9. BIRTHPLACE (CITY OR TOWN) Geb.
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Geo Hewett
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Pa
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Sarah Hewett
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ill
(STATE OR COUNTRY)

14. INFORMANT W T Larson
(Address) Hudson

15. Filed Dec 11, 27 — W. D. Jennings, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 7 1927

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ... 19... to Dec 7th 19...
that I last saw her alive on Dec 5th 1927, and that death occurred, on the date stated above, at 4 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Result of a wound in the right Temple from a Revolver (duration) ... yrs. ... mos. ... ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? ...
DID AN OPERATION PRECEDE DEATH? ... DATE OF ...
WAS THERE AN AUTOPSY? No. Coroners Inquest
WHAT TEST CONFIRMED DIAGNOSIS? ...

(Signed) W. D. Jennings M. D
, 19 (Address) Clinton Mo. 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 Hudson Church Cemetery — DATE OF BURIAL Dec 11 1927

20. UNDERTAKER W E Huston — ADDRESS Hudson

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.

USE OF DDT-1 in plain [illegible]
B- Prevention [illegible]

N. B.—... CAUSE OF ... REGISTRAR SHALL NOT ... CERTIFICATES ... UNTIL THEY ARE COMPLETE ... AS PRESCRIBED BY LAW

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 Henry — Registration District No. 14 — File No.

Township — Primary Registration District No. 4211 — Registered No. 40

City Windsor (No. St. Ward)

2. FULL NAME Elsie E Larison

(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	M

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ......min.
	40	11	22	

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 Dec 27 1927 T B Jennings REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 7 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:
Results of a wound in the face & head from a revolver, accidental
(duration) ......yrs. ......mos. ......ds. X

CONTRIBUTORY (SECONDARY) 183
(duration) ......yrs. ......mos. ......ds.

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

S-36097