

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

Do not use this space.

9727-a
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 315
 4311

1. PLACE OF DEATH

County McDonald Registration District No. 315 File No. 9727-a
 Township Prairie Primary Registration District No. 4311 Registered No. _____
 City Southwest City (No. _____) St. _____ Ward _____

2. FULL NAME Clifford Dale Elwood

(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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE of Child of Ella Elwood

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 17th 1928

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
		<u>2</u>	<u>14</u>	

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) Gravette Ark

10. NAME OF FATHER Ed Elwood
 11. BIRTHPLACE OF FATHER (CITY OR TOWN); (STATE OR COUNTRY) Arkansas
 12. MAIDEN NAME OF MOTHER Ella Bruce
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN); (STATE OR COUNTRY) Kansas

PARENTS

14. INFORMANT Ella Elwood
 (Address) Southwest City Mo

15. FILED 3/18 28 19 28 J. H. Nichols REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-17 19 28

17. I HEREBY CERTIFY That I attended deceased from 3-17 19 28, to _____ 19 _____, that I last saw him _____ alive on _____ 19 _____, and that death occurred, on the date stated above, at 7 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Indigestion
1180 (duration) Two Hours ds.

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? _____

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Cenical

(Signed) W. B. Ingram, M. D.

, 19 (Address) S. W. City 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 Southwest City, Mo DATE OF BURIAL 3/18 19 28

20. UNDERTAKER Nichols Bros ADDRESS Southwest City Mo



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Mc Donald Registration District No. 313 File No. _____
 Township Traverse Primary Registration District No. 4311 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Clifford Dale Elwood
 (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (write the word)

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)

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 _____ 19 _____ REGISTRAR John J. Nichol

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 17 19 28

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

Acute Indigestion
Gastritis

CONTRIBUTORY (SECONDARY) The Child was dead at the home when Physician arrived (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

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

S-9727A