

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

Do not use this space.

16279

1. PLACE OF DEATH

County Buchanan Registration District No. 85
Township _____ Primary Registration District No. 1001 File No. _____
City St. Joseph (No. Mo. 1001 Hospital _____ St. _____ Registered No. 679 Ward _____)

2. FULL NAME

George Washington Elliott
(a) Residence. No. 1773 Garfield St. _____ Ward. _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 44 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
5A. IS MARRIED, WIDOWED, OR DIVORCED? HUSBAND OR (OR) WIFE OF Rosal Elliott
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 10th 1856
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 71 79 8 13
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Contractor
(b) General nature of industry, business, or establishment in which employed (or employer) Building
(c) Name of employer Retired 1895

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Indiana

10. NAME OF FATHER

James Elliott

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER

Mary Stewart

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Unknown

14.

INFORMANT Florence Elliott
Address 1773 Garfield St

15.

FILED MAY 25 1928 19 _____
John G. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 23rd 1928

17. I HEREBY CERTIFY That I attended deceased from Jan 20, 1925, to May 23, 1928, that I last saw him alive on May 23, 1928, and that death occurred, on the date stated above, at 5:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

137 Broncho pneumonia
107 (duration) yrs. mos. 5 da.
137 Chronic postobitic with
1000 (SECONDARY) hemia (duration) yrs. 5 mos. 0 da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

1 DID AN OPERATION PRECEDE DEATH? No DATE OF May 22, 1928

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) P. R. Milled M. D.

5/26, 1928 (Address) 208 [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

Cremation 5/25 1928

20. UNDERTAKER

ADDRESS

[Signature] 216 00
1011

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

