

29 1928

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

Do not use this spare.

16317

1. PLACE OF DEATH

County Butler
Township
City Poplar Bluff (No. _____)

Registration District No. 89
Primary Registration District No. 3007

File No. _____
Registered No. 100
St. _____ Ward _____

2. FULL NAME

Elizabeth Mansfield
(a) Residence, No. 822 Duncan, St., _____ Ward _____
(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

MEDICAL CERTIFICATE OF DEATH

3. SEX

F.

4. COLOR OR RACE

W-

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

wid-

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

5-1 19 28

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

S. J. Mansfield

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1928, to May 1, 1928 that I last saw h. alive on May 1, 1928, and that death occurred, on the date stated above, at 5:30 A.M.

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

Feb. 14, 1869

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

65

2

17

Chronic interstitial nephritis
131
9241 290

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

CONTRIBUTORY Endocarditis
(SECONDARY)
(duration) 1 yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

mo -

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

10. NAME OF FATHER

Plummer

8 DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. M. Henrich, M. D.

5-5, 1928 (Address) Poplar Bluff

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

*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.

14. INFORMANT

W. J. Mansfield

(Address)

Allegan, Miss.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Black Creek

5-2 19 28

15. FILED

FILED

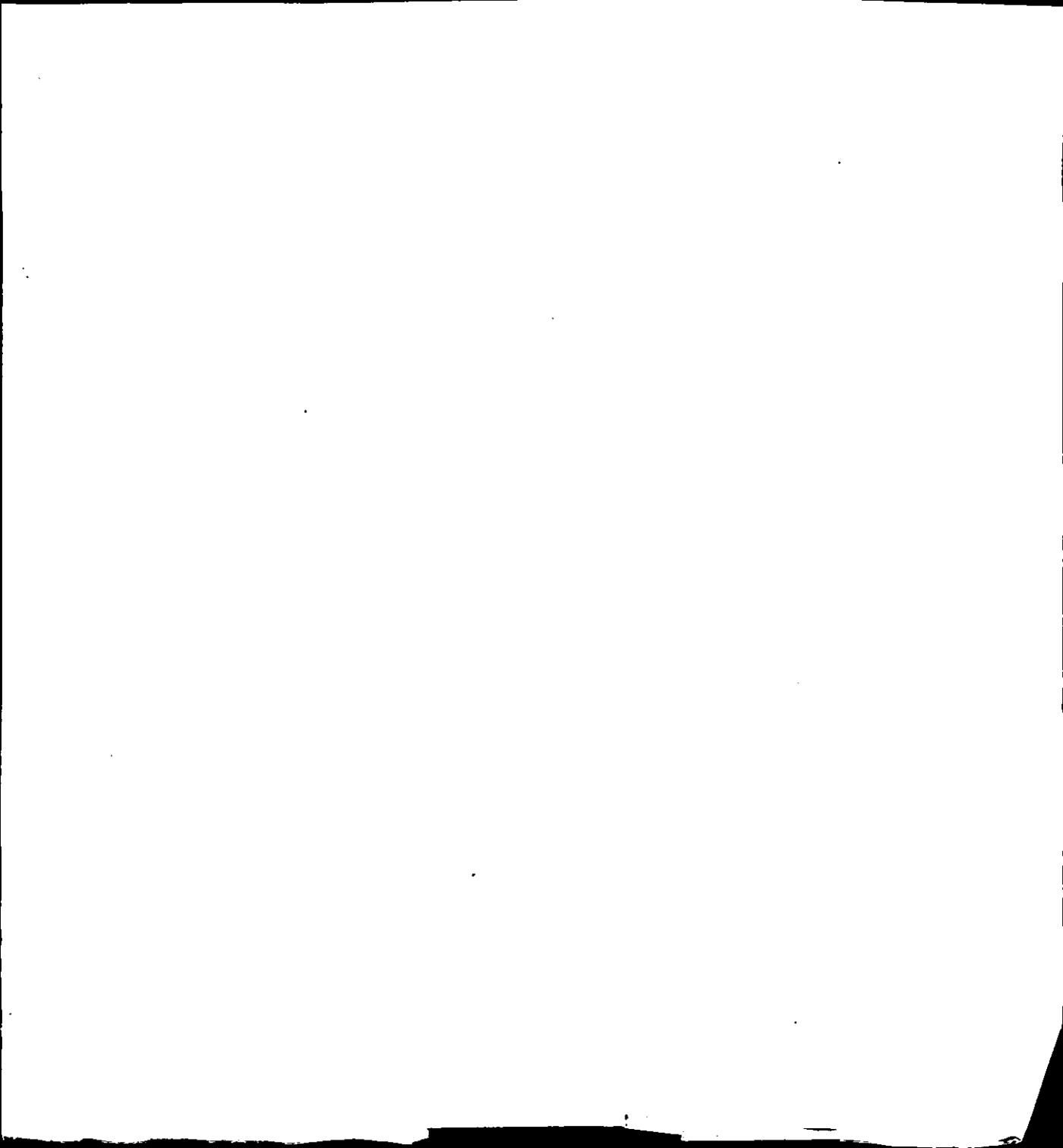
5/5 1928 S. R. Clay REGISTRAR

20. UNDERTAKER

ADDRESS

Franks Und. Co. Poplar Bluff

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
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County..... Butler Registration District No. 89 File No.
 Township..... Primary Registration District No. 3009 Registered No. 100
 City..... Opola, Mo. (No.) St. Ward (If nonresident give city or town and State)

2. FULL NAME..... Elizabeth Mansfield
 (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** W **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** wid
(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,**hra. ormin.

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-1-28

17. I HEREBY CERTIFY That I attended deceased from 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..... (duration).....yrs.mos.ds.
 (SECONDARY) (duration).....yrs.mos.ds.

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT (Address)

15. FILED 6/9 19 28 Dr. B. J. Clay REGISTRAR

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

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