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

Do not use this space.

18246

1. PLACE OF DEATH
County St. Francois
Township St. Francois
City Near Farmington (No. ..... St. ..... Ward)
Registration District No. 773
Primary Registration District No. 6018A
File No. .....
Registered No. 69

2. FULL NAME Ellen Loness
(a) Residence. No. State Hospital No. 4 St., ... Ward. Annapolis, Mo.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 6 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): Widow

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

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

7. AGE: Years 65; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN): Unknown
(STATE OR COUNTRY): Unknown - American

PARENTS
10. NAME OF FATHER: Not known
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Not known
(STATE OR COUNTRY): Not known
12. MAIDEN NAME OF MOTHER: Not known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): No known
(STATE OR COUNTRY): Not known

14. INFORMANT: Commitment Papers
(Address): ~~St. Francois~~ Farmington Mo

15. FILED 5-11-1928 B. J. Robinson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): May 10, 1928

17. I HEREBY CERTIFY, That I attended deceased from April 7, 1928, to May 10, 1928, that I last saw her alive on May 10, 1928, and that death occurred, on the date stated above, at 5:55 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis,
930
90B
(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? No. DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) Chas. R. Bunner, M. D
5-11-1928 (Address) State Hospital No. 4

*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: Redford - Mo
DATE OF BURIAL: 5-12-1928

20. UNDERTAKER: J. R. HORNE
ADDRESS: Elvins, 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.