

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

Do not use this space.

1. PLACE OF DEATH

County Macon
Township North
City macon mo (No.)

Registration District No. 333
Primary Registration District No. 3027

U 24411
File No.
Registered No. 74
St. Ward)

2. FULL NAME Eliza Q Kinder

(a) Residence. No. St. Ward.
(Usual place of abode)
Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 Joe Kinder

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ... hrs. or ... min.
54 | 7 | 11

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) Macon Mo Mo
(STATE OR COUNTRY)

10. NAME OF FATHER John Quigg

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

12. MAIDEN NAME OF MOTHER Sarah Morgan

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

14. INFORMANT Joe Kinder
(Address) macon mo

15. FILED 7/31, 1928 Mrs Luke Dunkel
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 7 1928

17. I HEREBY CERTIFY, That I attended deceased from Sept, 1923, to July 7, 1928 that I last saw her alive on July 7, 1928, and that death occurred, on the date stated above, at 6 P m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Cerebral hemorrhage
96
82 110
102 (duration) few hours ds.

CONTRIBUTORY (SECONDARY) Hypertension
Arteriosclerosis (duration) 8 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH: To

0 DID AN OPERATION PRECEDE DEATH? To DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Chinial
(Signed) Seward Miller, M. D.
7/8, 1928 (Address) macon. 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 Liberty cemetery DATE OF BURIAL 7-9-1928

20. UNDERTAKER Stephens F. Dunning ADDRESS macon mo

1910

1910

1

1910

1910

**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 Macon Registration District No. 533 File No. _____
 Township _____ Primary Registration District No. 3027 Registered No. 74
 City Macon (No. _____) St. _____ Ward _____

2. FULL NAME

Eliza Q Kinder
 (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

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 7 1928

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

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.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 26, 1873

THE CAUSE OF DEATH* WAS AS FOLLOWS: _____

7. AGE	YEARS	MONTHS	DAYS	*If LESS than 1 day, hrs. or min.
<u>54</u>	<u>9</u>	<u>11</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 _____

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? _____
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) _____, M. D.
 _____, 19____ (Address)

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 9/7 28 Mrs. Luke Hunkler REGISTRAR

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 TERMS, so that it may be properly classified. Exact statement of CAUSE OF DEATH I. TERMS, so that it may be properly classified. Exact statement of CAUSE OF DEATH I.

very important.

S-24411