

1928

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

Do not use this space.

34503

1. PLACE OF DEATH  
 County Randolph Registration District No. 735 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 3034 Registered No. 193  
 City Moberly (No. Mc Community Hospital) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Elsbeth Burnham  
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 11<sup>th</sup> 1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
62      10      29

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

9. BIRTHPLACE (CITY OR TOWN) Jonia  
 (STATE OR COUNTRY) Mo. Co. Mo.

10. NAME OF FATHER Richard Jones

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Endeavor  
 (STATE OR COUNTRY) \_\_\_\_\_

12. MAIDEN NAME OF MOTHER Essel Roney

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ohio  
 (STATE OR COUNTRY) \_\_\_\_\_

14. INFORMANT Sarah Smith  
 (Address) at Jess Mc

15. FILED 10/9, 1928 Dr. Thos. J. Fleming  
 REGISTRAR

D 3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 9 1928

17. I HEREBY CERTIFY, That I attended deceased from Sept 25, 1928, to Oct 9, 1928, that I last saw her alive on Oct 9, 1928, and that death occurred, on the date stated above, at 4:10 P. m.

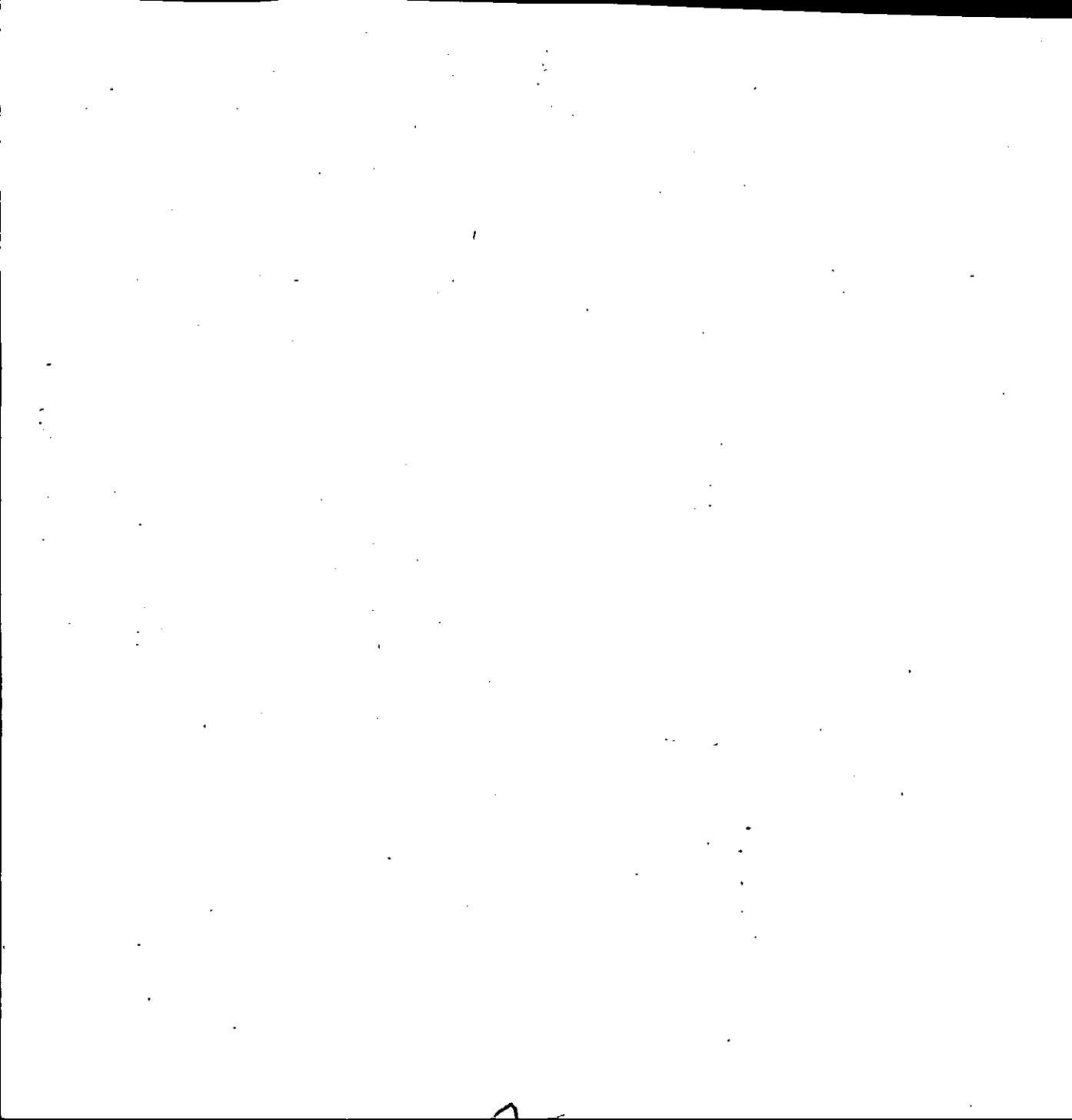
THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
myocarditis  
930  
 (duration) yrs. 6 mos. da.  
 CONTRIBUTORY Arterian Cyst & Fibroid  
 (SECONDARY) (duration) 2 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? yes, DATE OF Sept 25  
 WAS THERE AN AUTOPSY? no  
 WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_  
 (Signed) F. L. McCormick, M. D.  
 , 19 (Address) Moberly 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 Concord DATE OF BURIAL 10/11 1928

20. UNDERTAKER Alvin Fleming ADDRESS Moberly Mo.



**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 Randolph Registration District No. 435- File No. ....  
Township ..... Primary Registration District No. 3034 Registered No. 193  
City Moberly (No. ....) St. .... Ward)

**2. FULL NAME**

Elizabeth Burnham  
(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 (write the word) m

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 10/9/28 Dr. Harold Fleming  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 9 1928

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

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

Myocarditis  
(duration) ..... yrs. .... mos. .... ds.  
CONTRIBUTORY (SECONDARY) Coronary Cyst & fibroid  
carcinomatous (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

20. UNDERTAKER ADDRESS

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

SUPPLEMENTARY

S-34503