

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

Do not use this space.

143

1. PLACE OF DEATH

County Bates
Township West Boone
City (No.) St. Ward

Registration District No. 5-2
Primary Registration District No. 5-0 P-0

File No.
Registered No. 1
St. Ward

2. FULL NAME

Bailey Jackson Elder

(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 Male | 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 Lois Elder

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr-2-1877

7. AGE YEARS MONTHS DAYS | If LESS than 1 day, hrs. or min.
51 | 9 | 12

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Atchison Co Kans

10. NAME OF FATHER Jan B. Elder

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Rau Co Mo.

12. MAIDEN NAME OF MOTHER Sarah M Sutton

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Clay Co. Mo.

14. INFORMANT Mrs. B. J. Elder (Address) Drexel Mo.

15. FILED 1/14, 1929 E. E. Shooney REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 14 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 14 1929 to Jan 14 1929, and that I last saw him alive on Jan 14 1929, and that death occurred, on the date stated above, at 4 4 P. M.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Cancer of the stomach
4 4 P. M. 118 8 4
CONTRIBUTORY (SECONDARY) Remarriage of stomach (duration) yrs. mos. ds. 12

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH, DATE OF

DID AN OPERATION PRECEDE DEATH, DATE OF

19. WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) P. F. Satterly M. D. (Address) Louisburg 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.

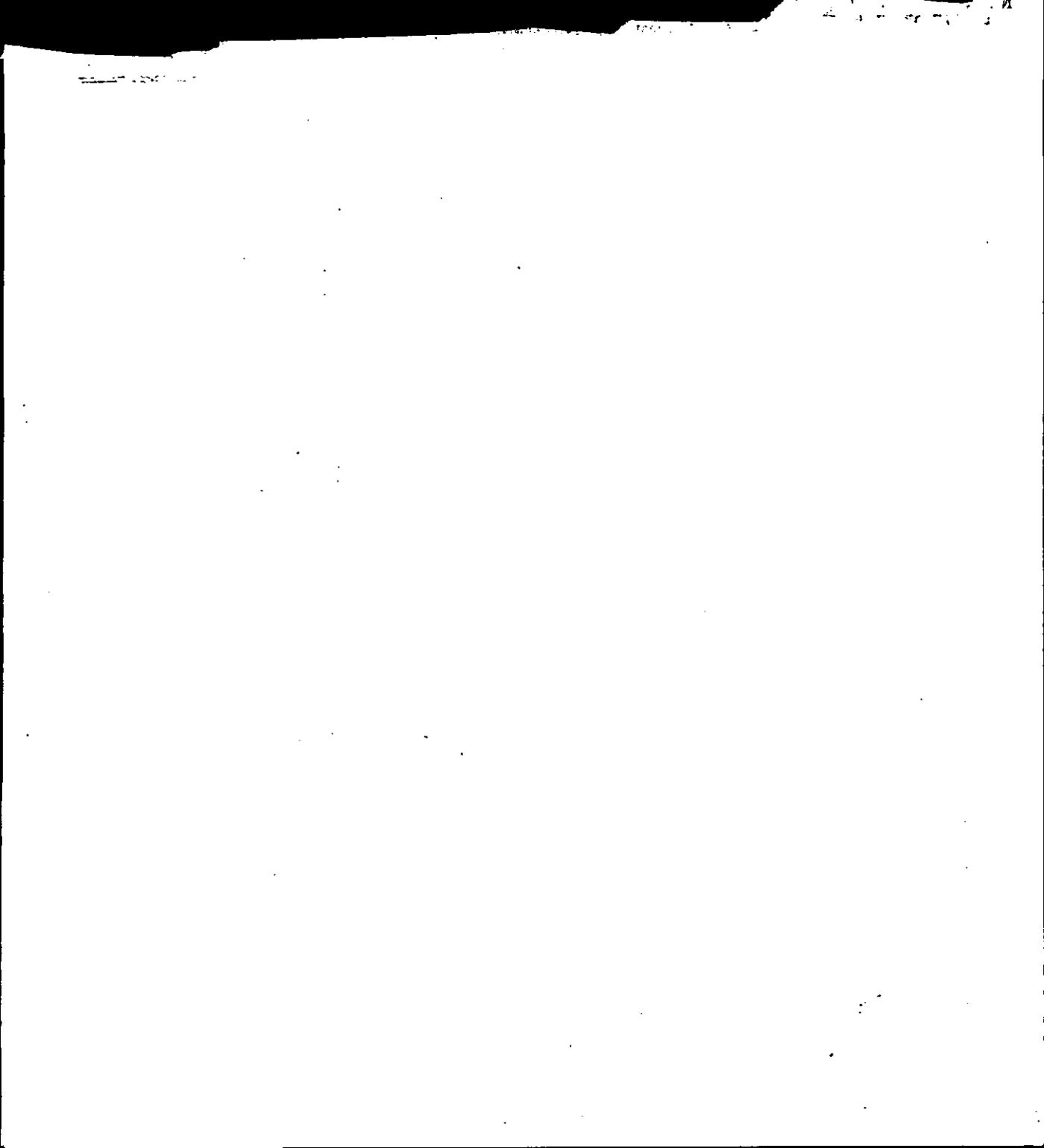
19. PLACE OF BURIAL, CREMATION, OR REMOVAL Stellwater Ok. DATE OF BURIAL 1929

20. UNDERTAKER J. B. Hays ADDRESS Drexel Mo

N. E.—Every item of information CAUSE OF DEATH in plain terms, sec. 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

CO. 2411

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**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 Bates
Township West Boone
City (No.) St. Ward)

Registration District No. 52
Primary Registration District No. 2-080

File No.
Registered No.

2. FULL NAME

Bailey Jackson Elder

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

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 (duration) yrs.
(b) General nature of industry, business, or establishment in which employed (or employer) (duration) yrs.
(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 1/14 1929 E.E. Shooney REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 14 1929

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (duration) yrs.
SECONDARY (duration) yrs.

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).....

, 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

Stillwater Okla. 1929

20. UNDERTAKER ADDRESS

J.B. Hayes Drexel mo

SUPPLEMENTARY

Subject to [Signature] Jan 14 - 1929

N. B. Every item of information on which a fee is supplied, AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESENTED.

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