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

Do not use this space.

2193

1. PLACE OF DEATH
County Laclede — Registration District No. 449 — File No.
Township — Primary Registration District No. 4267 — Registered No. 1573
City Lebanon (No. ..... St. ..... Ward)

2. FULL NAME Eliza Jane Pack
(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(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

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 23-1845

7. AGE: 83 YEARS — MONTHS: 10 — DAYS: 14 — If LESS than 1 day, ... hrs. or ..... min.

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

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

PARENTS

10. NAME OF FATHER Matt Brookshire
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Kentucky
12. MAIDEN NAME OF MOTHER Eliza Guinn
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Kentucky

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14. INFORMANT Lea King
(Address) Lebanon Mo

15. FILED 1/8, 1929 J M Billing REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 7 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 4, 1929, to Jan 4, 1929 that I last saw her alive on Jan 4, 1929, and that death occurred, on the date stated above, at 4 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Influenza —
11B
162 11B
(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (SECONDARY) Senility —
(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? Physical Exam
(Signed) P Humphrey, M. D
, 19 (Address) Lebanon 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: Stephens Cemetery — DATE OF BURIAL: 1-9 1929

20. UNDERTAKER: Hofman & Stewart — ADDRESS: Lebanon Mo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.