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

Do not use this space.

5475

85

1001

1. PLACE OF DEATH
County Buchanan — Registration District No. 1001 — File No.
Township — Primary Registration District No. — Registered No. 136
City St Joseph (No. State Hospital 2 St. Ward)

2. FULL NAME Eliza J. Hull
(a) Residence. No. State Hosp# 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. 10 mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

MAR 21 1929

11

8

9

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) about 1837 unknown

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
92	X	X	

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

235

9. BIRTHPLACE (CITY OR TOWN) unknown.
(STATE OR COUNTRY)

31

PARENTS

10. NAME OF FATHER unknown

31

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

12. MAIDEN NAME OF MOTHER unknown

31

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

14. INFORMANT records
(Address) State Hospital #2

15. FILED FEB 4 1929 John T. Utz REGISTRAR

MEDICAL CERTIFICATE OF DEATH

1

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

17. I HEREBY CERTIFY, That I attended deceased from Jan 25-29, 19..., to Feb. 1, 1929 that I last saw her alive on Feb 1, 1929 and that death occurred, on the date stated above, at 8:00 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis.
93c
unknown (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH? unknown.

0 DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no.

WHAT TEST CONFIRMED DIAGNOSIS? clinical.

(Signed) E. D. Berends, M. D
2/2, 1929 (Address) State Hosp #2

*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 Farofield Pen — DATE OF BURIAL 2/5 1929

20. UNDERTAKER J. L. Shingley — ADDRESS 21600 1 ad.

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.

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No.....

City..... (No..... St. ..... Ward)

2. FULL NAME.....

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

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)

PARENTS

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....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(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?..... 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 19
20. UNDERTAKER	ADDRESS

WHITE PRINTING, WITH ORIGINAL 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.