

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

Do not use this space.

10112-A

File No. 3
Registered No. 253
St. _____ Ward _____

10112-1-34

1. PLACE OF DEATH
County Stevens Registration District No. 253
Township _____ Primary Registration District No. 2361
City Fochsprings (No. _____) St. _____ Ward _____

2. FULL NAME Elizabeth Ann M. Cluse
(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 85 yrs. mos. _____ ds. How long in U.S., if of foreign birth? 87 yrs. mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 5 - 1842

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
	<u>87</u>		<u>20</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(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) Fochsprings Mo

10. NAME OF FATHER J. B. Munnicks

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

12. MAIDEN NAME OF MOTHER Nancy E. Clifford

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

14. INFORMANT (Address) J. R. Munnicks
Ernoga, Iowa

15. File No. 26 1929 Registrar A. G. Minnich

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 25 - 1929

17. I HEREBY CERTIFY, That I attended deceased from Mar. 18 - 1929, to Mar. 25 - 1929 that I last saw h. alive on Mar. 24 - 1929, and that death occurred, on the date stated above, at 9 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of the Uterus

CONTRIBUTORY (SECONDARY) 46
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED? ✓
IF NOT AT PLACE OF DEATH, _____

19. DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

20. WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Chin
(Signed) A. G. Minnich, M. D.

*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 Fochsprings DATE OF BURIAL 3-27-29

20. UNDERTAKER F. B. Norman ADDRESS Chellecothe Mo

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.

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