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

Do not use this space. 13729

1. PLACE OF DEATH

County Andrew — Registration District No. 13 — File No.

Township — Primary Registration District No. 4010 — Registered No. 20

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

2. FULL NAME Eliza Jane Hall

(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): widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: David Irwin Hall

6. DATE OF BIRTH (MONTH, DAY AND YEAR): May 6 1859

7. AGE: 69 ~~79~~ YEARS, MONTHS: 11, DAYS: 17 — If LESS than 1 day, ... hrs. or ..... min.

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): Andrew Co Mo.

PARENTS

10. NAME OF FATHER: Brand
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown
12. MAIDEN NAME OF MOTHER: Ann Known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): un Known

14. INFORMANT: W. W. Hall (Address) Savannah Mo.

15. FILED Apr 25 1929 C Jeffries MD REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Apr 23 1929

17. I HEREBY CERTIFY, That I attended deceased from 4-19 1929, to 4-23 1929, that I last saw her alive on 4-21 1929, and that death occurred, on the date stated above, at 12:45 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Angina Pectoris

(duration) 1 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) Wood Martin, M. D

4-24 1929 (Address) Savannah

*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: Savannah — DATE OF BURIAL: 4-25 1929

20. UNDERTAKER: E. C. Breit — ADDRESS: Savannah 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.