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

Do not use this space.

17692

MAY 24 1929

1. PLACE OF DEATH
County Dade
Township E. Center
City Greenfield. (No. ..... St. ..... Ward)

Registration District No. 237
Primary Registration District No. 5323

File No. 22
Registered No. .....

2. FULL NAME Elizabeth Zinn.

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

5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND~~ OF (OR) WIFE OF Peter Zinn.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 17. 1842

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
86	6	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House keeping
(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) Harrison Co.
(STATE OR COUNTRY) W. Va.

PARENTS

10. NAME OF FATHER C. Carder.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) W. Va.
12. MAIDEN NAME OF MOTHER Mary Golden
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) W. Va.

2

2

2

14. INFORMANT Mrs. Chas. Hickey
(Address) Greenfield. Mo. R# 3

15. FILED 5-13, 1929 B. O. Ball
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-13 1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to 5-2, 1929, that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 5-13 m29

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Complication following Flu
11B
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 11B
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) O. V. Hembree, M. D
, 19 (Address) Greenfield 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 Pierce City Cem.
DATE OF BURIAL May 14 1929

20. UNDERTAKER J. W. Ward.
ADDRESS Greenfield 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.