

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

Do not use this space.

18747

**PLACE OF DEATH**

County Mason Registration District No. 638  
 Township Fredericktown Primary Registration District No. 3044  
 City Fredericktown No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. \_\_\_\_\_  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Elpira Venable  
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

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

5A. IF MARRIED, Widower or Divorced  
 HUSBAND OF John Venable  
 (OR) WIFE OF wife of John Venable

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 9-1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
62 | 2 | 2 | \_\_\_\_\_

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

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

10. NAME OF FATHER Eliezer Powell

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

12. MAIDEN NAME OF MOTHER don't know

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

14. INFORMANT Esther Venable  
 (Address) Fredericktown, Mo

15. FILED Nov 21 1929 O. V. Wain REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 11 1929

17. I HEREBY CERTIFY That I attended deceased from Apr 29 1929 to May 11 1929 that I last saw her alive on May 10 1929, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

131  
132 B (duration) yrs. mos. da.

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

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? Sloughs  
 (Signed) [Signature] M. D.  
May 19 1929 (Address) Fredericktown, 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 9007 Fredericktown DATE OF BURIAL May 12 1929

20. UNDERTAKER Ed. H. Webb ADDRESS Fredericktown

UN 26 1929  
 DEATH in plain terms, so  
 2  
 8  
 8

100-100000-100000

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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Madison Registration District No. 538 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 3024 Registered No. \_\_\_\_\_  
 City Fredericktown (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Elvina Venable  
 (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 <u>♀</u>		4. COLOR OR RACE <u>W</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>m</u>	
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)				

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 11 1929

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:  
Wernia  
 \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 CONTRIBUTORY (SECONDARY) Chr. Hypertension  
 \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 21 ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH  
 DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
 WAS THERE AN ALCOHOLIST? \_\_\_\_\_  
 WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) [Signature], 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.

14. INFORMANT (Address)	19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
15. <u>[Signature]</u> REGISTRAR	20. UNDERTAKER	19____ ADDRESS

SUPPLEMENTARY

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. Every statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

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