

AUG 22 1929

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

Do not use this space.

23758

1. PLACE OF DEATH

County Bates
Township West Boone
City _____ (No. _____) St. _____ Ward _____

Registration District No. 52
Primary Registration District No. 5080

File No. _____
Registered No. 4

2. FULL NAME

Elsie Leonora Harrison
(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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar-31-1913

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
16 4 0

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) Bates Co Mo
(STATE OR COUNTRY)

10. NAME OF FATHER W. Harrison

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

12. MAIDEN NAME OF MOTHER Elizabeth Harris

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

14. INFORMANT Permesa Bailey
(Address) Edwardsville, Kaso.

15. FILED 8/2 1929 E. E. Shockey
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July-31-1929

17. I HEREBY CERTIFY, That I attended deceased from June 26, 1928, to July 31, 1929 that I last saw him alive on July 31, 1929, and that death occurred, on the date stated above, at 5:25 p. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Acute Bilateral Nissamath
Ulcerative Pulmonary
Tuberculosis
2 1/2 (duration) 1 yrs. 1 mos. 5 ds.
CONTRIBUTORY (SECONDARY) Ulcerative T. b. e.
enteritis (duration) 4 yrs. 4 mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) B. O. Hartwell, M. D.

Aug-1-, 1929 (Address) Drexel 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 Edgewood Cem

DATE OF BURIAL Aug-2-1929

20. UNDERTAKER Shockey

ADDRESS Drexel 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.

