

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

Do not use this space.

**1. PLACE OF DEATH**

County Lawrence  
Township Lincoln  
City (No. ....) .....

Registration District No. 469  
Primary Registration District No. 5630

File No. 025114  
Registered No. ....  
St. .... Ward)

**2. FULL NAME**

Tobiasia Elizabeth Isbel

(a) Residence. No. .... St. .... Ward. ....  
(Usual place of abode)

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 Reighley Isbel

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1862

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 housekeeper  
(b) General nature of industry, business, or establishment in which employed (or employer) .....

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

10. NAME OF FATHER Edmon S Ford

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

12. MAIDEN NAME OF MOTHER Elizabeth Wilson

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

14. INFORMANT Jim P. Ford  
(Address)

15. FILED ..... 19..... REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19 .....

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:

463  
..... (duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY) .....

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) ....., 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Stahl DATE OF BURIAL 7-16-1929  
20. UNDERTAKER J.W. Morris & Leiman Miller Mo. ADDRESS

N. B.—Every CAUSE OF DEATH should be stated EXACTLY as it properly classified. Exact statement of CAUSE OF DEATH is very important.

286 1929

THE STATE OF CALIFORNIA,  
COUNTY OF LOS ANGELES,  
do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears on the records of the County Clerk of the County of Los Angeles, California.

**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 Lawrence Registration District No. 469 File No. \_\_\_\_\_  
 Township Lincoln Primary Registration District No. 3630 Registered No. \_\_\_\_\_  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Tobisia Elizabeth Isabel

(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) W

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (OR) WIFE of Righley Isabel

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 1862

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. work woman

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work housekeeper  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-15-29

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_ that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Cancer of stomach

CONTRIBUTORY (SECONDARY) 440 (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?  
 (Signed) W. S. Denny, M. D.  
 \_\_\_\_\_ 19\_\_\_\_ (Address) Miller

\*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Stahl DATE OF BURIAL 7-16-29

20. UNDERTAKER J. W. Morris & Leiman ADDRESS Miller

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Mo

10. NAME OF FATHER Edmon Ford

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Tenn

12. MAIDEN NAME OF MOTHER Elizabeth Wilson

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

14. INFORMANT Jim Ford (Address) \_\_\_\_\_

15. FILED 8-19-29 W. S. Denny REGISTRAR

SUPPLEMENTARY

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. REGISTERED FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-25114