

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

12-22
Do not use this space.

26883

1. PLACE OF DEATH

County Andrew Registration District No. 26 File No. _____
 Township Salt River Primary Registration District No. 5034 Registered No. _____
 City Merica Mo RFD (No. _____) St. _____ Ward _____

2. FULL NAME Lizzie B. Curtis

(a) Residence. No. Andrew Co Mo 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov-20-1873

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>75</u>	<u>8</u>	<u>27</u>		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Stinejohns
 (STATE OR COUNTRY) Ind

10. NAME OF FATHER W.H. Trumbull

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

12. MAIDEN NAME OF MOTHER Mrs. Thompson

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

14. INFORMANT John W. Elin
 (Address) Molins Mo.

15. Aug 19th 1929 Ira S. Willigan
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug-18-1929

17. I HEREBY CERTIFY, That I attended deceased from Aug-7-1929, to Aug-18-1929, that I last saw her alive on Aug-17-1929, and that death occurred, on the date stated above, at 12:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ovarian cyst with twisted pedicle. I think

1194
5-4A Removal (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 _____

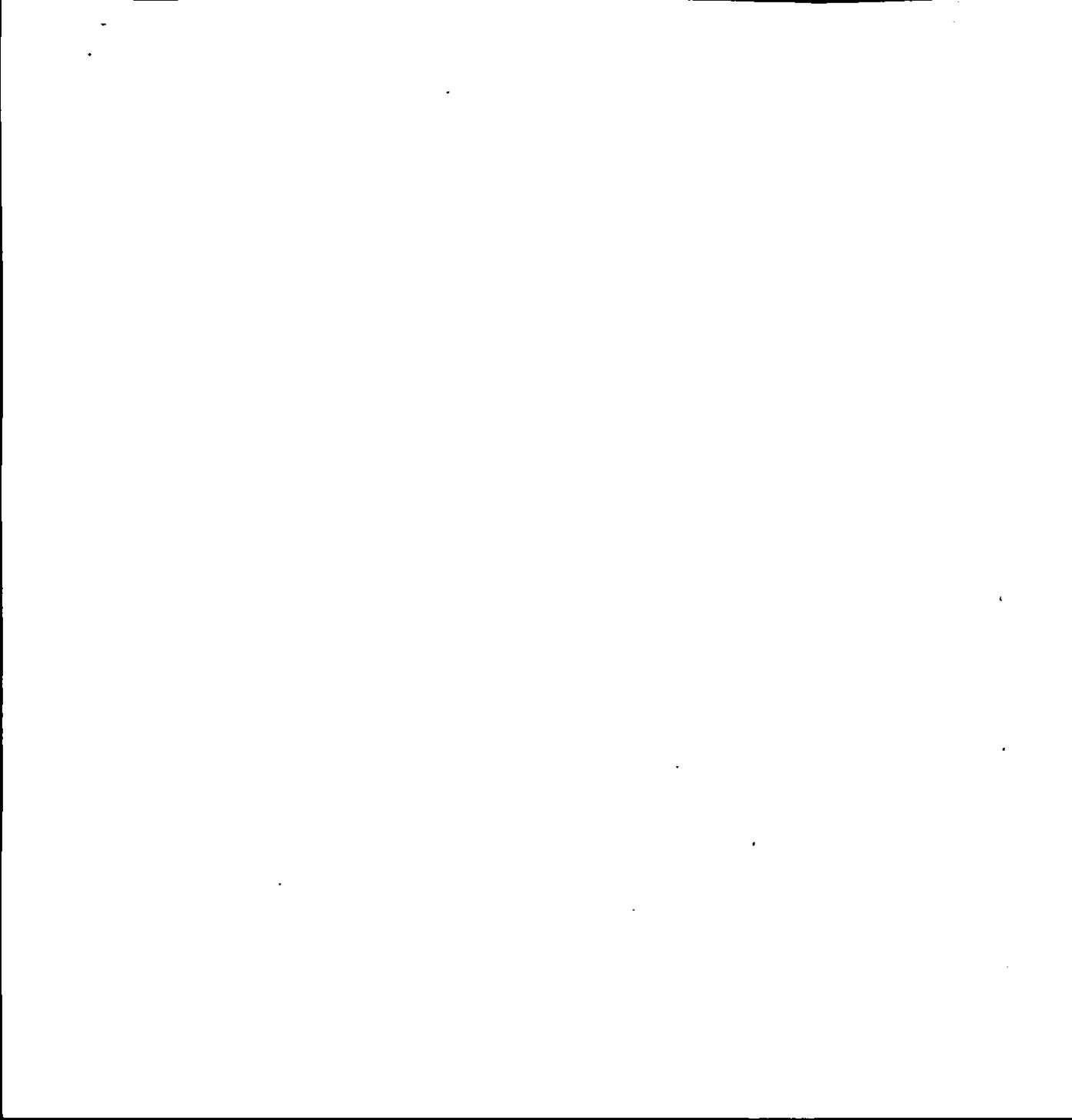
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) W.H. Brown, M. D.

*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 Barren Mo Cem DATE OF BURIAL 8-19-1929

20. UNDERTAKER W.A. Precht & Son ADDRESS Merica



**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 Cass
Township Waltham
City..... (No.....).....St.Ward)

Registration District No. 26
Primary Registration District No. 1034

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

2. FULL NAME

Lizzie B. Ellis

(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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. ormin.

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)

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)

14. INFORMANT.....
(Address)

15. FILED Aug 19th 1929 Ira S. Milligan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 18 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:

Overgrown cyst - with twisted pedicle I think of malignant cancer 44
(duration).....yrs.....mos.....ds.

CONTRIBUTORY (SECONDARY)

46

(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)....., 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 DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

SMALL NOT IN GIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

S-26883