

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

Do not use this space.

32834

1. PLACE OF DEATH

County North

Registration District No. 905

Township Demarest

Primary Registration District No. 0216

City Demarest (No. _____)

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Eliza Ann Henton

(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

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

Edgar M. Henton

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

April 18 - 1873

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

56

4

20

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Housewife

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Leath, Mo.

(STATE OR COUNTRY)

10. NAME OF FATHER

W. Campbell

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Jay County, Indiana

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Malinda P. Cook

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Waverly, Iowa

(STATE OR COUNTRY)

14. INFORMANT

(Address)

Edgar M. Henton
Demarest, Mo.

15. FILED

19

REGISTRAR

2

MEDICAL CERTIFICATE OF DEATH

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

Sept. 8, 1929

17.

I HEREBY CERTIFY, That I attended deceased from _____

1929 to Sept. 8, 1929

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:

myocarditis
chronic interstitial nephritis
(duration) 1 yrs. _____ mos. _____ ds.
(SECONDARY) 9 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)

James H. Kery, M. D.

, 19

(Address)

Demarest, 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

DATE OF BURIAL

New Cemetery

Sept. 10, 1929

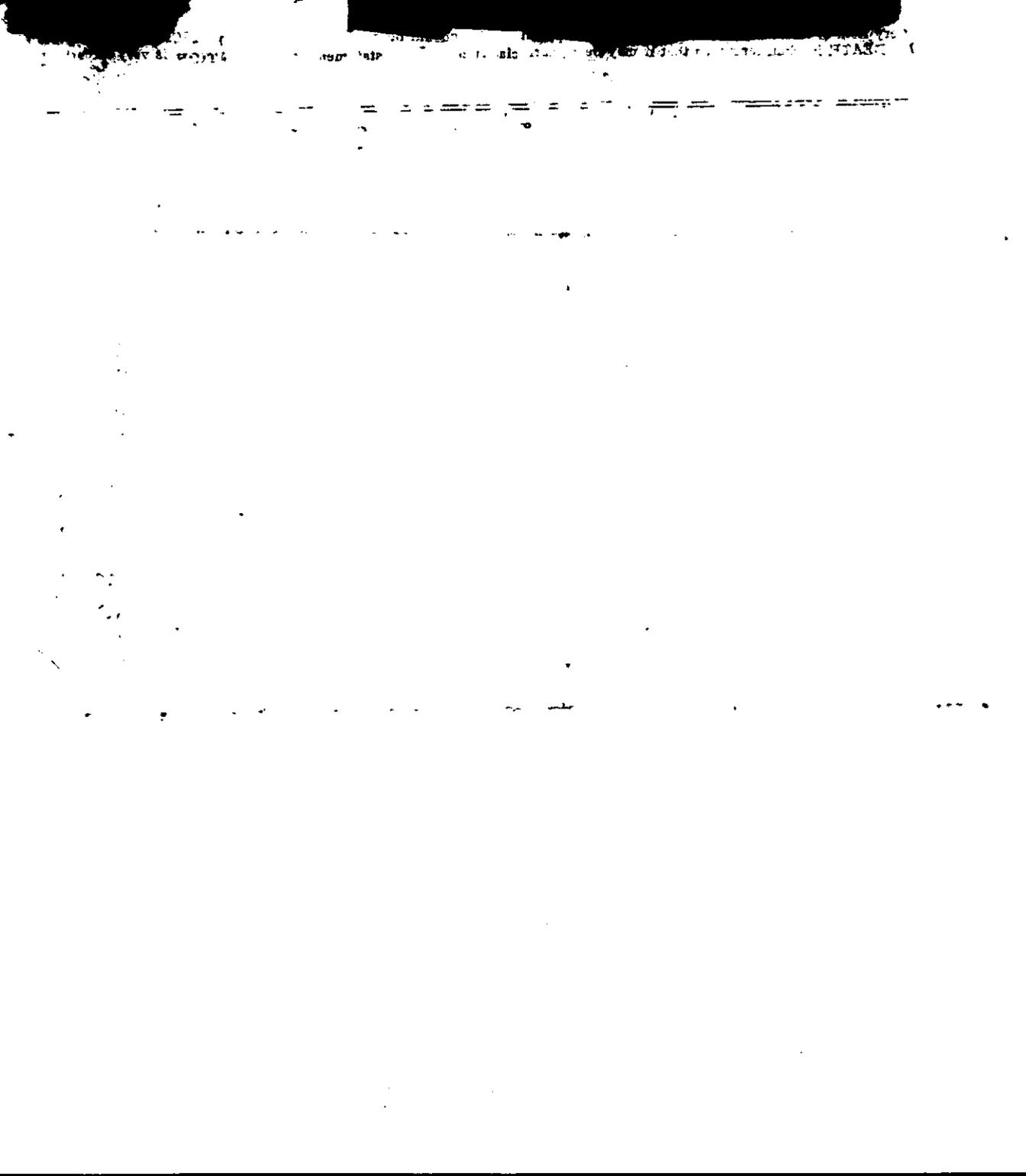
20. UNDERTAKER

ADDRESS

Bram Brox

Demarest

PERMANENT RECORD - Every statement of OCCUPATION is verified. Exact statement of OCCUPATION is verified. CAUSE OF DEATH in plain terms, so that it may be reported.



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Worth
Township Allen
City..... (No..... St..... Ward)

Registration District No. 905-
Primary Registration District No. 6214

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

2. FULL NAME

Eliza Ann Hunter

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M
(write the word)

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

14. INFORMANT (Address)

15. FILED Oct 10 1929 Mrs Maye Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 8 - 1929

17. I HEREBY CERTIFY That I attended deceased from to 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:

CONTRIBUTORY (SECONDARY) (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

20. UNDERTAKER ADDRESS

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 and mode of death, so that it may be properly classified. Exact statement of OCCUPATION is of great importance. REGISTERED PHYSICIANS ONLY ARE COMPLETE AS PER LAW

SUPPLEMENTARY

S-32834