

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

Do not use this space.

33090

1. PLACE OF DEATH

County Buchanan

Registration District No. 85

Township

City St. Joseph,

Primary Registration District No. 1001
(No. 321 North 10th.)

File No.

Registered No. 1234

St. Ward)

2. FULL NAME Elizabeth Jane Ransom,

(a) Residence No. 321 No. 10th.

(Usual place of abode)

St. Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 72

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

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

Widowed,

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF (OR) WIFE OF

Daniel Ransom,

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 3rd. 1831

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1

98

3

27

day, hrs. or min.

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)

Philadelphia,

(STATE OR COUNTRY)

Pennsylvania,

10. NAME OF FATHER

William H. Steele,

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Boston,

(STATE OR COUNTRY)

Massachusetts,

12. MAIDEN NAME OF MOTHER

Charlotte Westcott

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Unknown,

(STATE OR COUNTRY)

New Jersey,

14. INFORMANT

Miss Emma J. Ransom

(Address) 321 North 10th Street,

15. FILED

31 1929

John L. [Signature]
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 30 1929

17.

I HEREBY CERTIFY, That I attended deceased from

Oct. 25

1929

Oct 25

1929

that I last saw her alive on Oct 25 1929, and that death occurred, on the date stated above, at 9:45 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock sepsis following fracture tibia/fibula and numerous rib fractures
186A

CONTRIBUTORY (SECONDARY)

Some esophageal 98 years (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)

Geo. J. Geiger, M. D.

(Address) 1019 [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

Mount Mora Cemetery,

Nov. 1st, 29

20. UNDERTAKER

ADDRESS

Horton Belloni & Bowman
Funeral Home

319 S. 10 St.

At. [unclear] information should be carefully supplied. [unclear] statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

2335

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**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 DuChane Registration District No. 83 File No. _____
 Township _____ Primary Registration District No. 1001 Registered No. 1294
 City St. Joseph (No. _____) St. _____ (Ward _____)

2. FULL NAME

Elizabeth Jane Parsons
 (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) 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. 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) _____

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 127 - 19 29 John Stutz REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 30 1929

17. I HEREBY CERTIFY that I attended deceased from _____ 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:
Shock & sepsis following fractured fibula tibia & numerous bed sores!
 (duration) _____ yrs. mos. ds.
 CONTRIBUTORY Senility age 98 yrs.
 (SECONDARY) Blind 36 years. Full out of bed
 (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) Jacob Heigel, 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

informant's position not

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-3300