

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

Do not use this space.

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1. PLACE OF DEATH

County Boone Registration District No. 72 File No. _____
 Township Centralia Primary Registration District No. 404 5111 Registered No. 3
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

David Newton Elliott

(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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (OR) WIFE of Belle Elliott

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 13 - 1850

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
72 | 9 | 14

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Morgan Elliott

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

12. MAIDEN NAME OF MOTHER Un Known

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

14. INFORMANT E. Elliott (Address) 807-W. Crawford St. Hannibal

15. FILE NO. 128-30 REGISTRAR J. F. [Signature]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 27 1930

17. I HEREBY CERTIFY That I attended deceased from _____, 1925, to _____, 1930, that I last saw him alive on _____, 1930, and that death occurred, on the date stated above, at _____, 5:30 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Endo Carditis

92H

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) St. G. White, M. D.

Jan 24, 1930 (Address) Centralia 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 Centralia Mo DATE OF BURIAL 1-28 1930

20. UNDERTAKER M. J. McDonald ADDRESS Centralia Mo

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.

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