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: Cape Girardeau — Registration District No.: 150
Township: Liberty — Primary Registration District No.: 5181
City: ..... (No. ..... St. ..... Ward)
File No. .....
Registered No. .....

2. FULL NAME: Emanda Elizabeth Prosser.
(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: 20 yrs. 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): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Wife of John W. Prosser

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Sep. 9 - 1854

7. AGE: Years 75 — Months 4 — Days 11 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(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): Stoddard Co. Mo.

PARENTS
10. NAME OF FATHER: Peter Prosser.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Does not know
12. MAIDEN NAME OF MOTHER: Does not know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Does not know

14. INFORMANT (Address): John W. Prosser Crump, Mo.

15. FILED 1/20 1930 J. M. Slagle REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan. 20 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan. 8, 1930, to Jan. 20, 1930 that I last saw her alive on Jan. 18, 1930, and that death occurred, on the date stated above, at 8 50 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Pulmonary Tuberculosis

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(duration) 10 yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Do not
Do not know (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? at Place of death
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? Physical Examination
WHAT TEST CONFIRMED DIAGNOSIS? none

(Signed) J. M. Penney, M. D.
19 (Address) Whitewater 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: Prosser Cemetary — DATE OF BURIAL: Jan. 21 1930

20. UNDERTAKER: W. A. Anger. — ADDRESS: Leopold 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.

WRITE PLAINLY, WITH PUNTABING INK—THIS IS A PERMANENT RECORD

FEB 18 1930

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