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

Do not use this space.

3767

FEB 20 1930

1. PLACE OF DEATH
County Sullivan — Registration District No. 852 — File No.
Township Polk — Primary Registration District No. 4518 — Registered No. 1
City Milan (No. ..... St. ..... Ward)

2. FULL NAME Elizibeth Julia McConkey
(a) Residence. No. ..... St., ... Ward. (If nonresident, give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 16, 1850.

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	78	4	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House keeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Galesburg, (STATE OR COUNTRY) Illinois

PARENTS
10. NAME OF FATHER David Taylor
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Shelby Co., (STATE OR COUNTRY) Kentucky.
12. MAIDEN NAME OF MOTHER Susan McFarland
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Green Co., (STATE OR COUNTRY) Kentucky.

14. INFORMANT Wm. D. McConkey (Address) Milan, Mo

15. FILED 1-5, 1930 Bertha McClary REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 3 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 1929, to Jan 2, 1930 that I last saw her alive on Jan 2, 1930, and that death occurred, on the date stated above, at 6 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral insufficiency
929
102
(duration) 5 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Hypertension
(duration) 5 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? no
(Signed) E. W. Hickman, M. D.
Jan 3, 1930 (Address) Milan 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
Oakwood Cem Milan	Jan 4 1930
20. UNDERTAKER	ADDRESS
C. A. Schoene	Milan, 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.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
County: Sullivan — Registration District No.: 83-2 — File No.:
Township: — Primary Registration District No.: 4-5-18 — Registered No.: 1
City: Milan (No. ..... St. ..... Ward)

2. FULL NAME: Elizabeth Lena McConkey
(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(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.

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): Aug 16, 1850

7. AGE: Years 78 | Months 4 | Days 17 | 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)

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 1-5, 1930 Beritha McClary
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 3 1930

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:

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

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 19

20. UNDERTAKER | ADDRESS

SUPPLEMENTARY

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.

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