MAR 28 1930

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

Do not use this space.

5669

1. PLACE OF DEATH
County Harris
Township Jackson
City (No. St. Ward)
Registration District No. 542
Primary Registration District No. 5731
File No. 4
Registered No. 1

2. FULL NAME Annie Bell Elrod
(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: 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

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

7. AGE: YEARS 80 | MONTHS 1 | DAYS 26 | If LESS than 1 day, X hrs. or X 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): House work
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Phelps Co. Mo.

PARENTS
10. NAME OF FATHER: Thomas Whalen
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ed. Lauir, Ill.
12. MAIDEN NAME OF MOTHER: Emma Blank
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Phelps Co. Mo.

14. INFORMANT: Allen Elrod
(Address): Dunna Mo

15. FILED Mar-4th, 1930 Lorenzo W. Eads REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Feb. 10th, 1930 to Feb. 20th, 1930 that I last saw her alive on Feb. 18th, 1930, and that death occurred, on the date stated above, at 2 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Puerperal Insanity
145 A
150 A (duration) yrs. mos. 6 ds.

CONTRIBUTORY (SECONDARY): Puerperal Infection
(duration) yrs. mos. 6 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? No
WHAT TEST CONFIRMED DIAGNOSIS? History & Symptoms
(Signed) W. R. Ferrell M.D.
, 19 (Address) Belle, 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: Elrod Cemetery
DATE OF BURIAL: 2-22-1930

20. UNDERTAKER: S. G. Lickhider
ADDRESS: Belle, Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

SEP 9

2-20-30
30

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: Morgan — Registration District No.: 342 — File No.: 4
Township: Jackson — Primary Registration District No.: 5431 — Registered No.:
City: , (No. , St. Ward)

2. FULL NAME: Annie Bell Elrod

(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*): M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec-24-1894

7. AGE: YEARS 30 | MONTHS 1 | DAYS 26 | 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 3/4, 30 Lorenzo W. Eudy
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

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

Does signing twice make it better?

Dec-24-1899-
30

1929-

~~Jan 24-1930~~

5-5669