

Shelton
Do not use this space.

5703

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

MAR 28 1930

1. PLACE OF DEATH

County Miller Registration District No. 561
Township Saline Primary Registration District No. 4330
City _____ (No. _____) St. _____ Ward _____

File No. _____
Registered No. 19

2. FULL NAME

Victoria Clida Isabel

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 5 1898

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
31 11 4

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

9. BIRTHPLACE (CITY OR TOWN) milagro
(STATE OR COUNTRY) E. of Ecuador

10. NAME OF FATHER Francisco M. Diaz

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Vinces
(STATE OR COUNTRY) Ecuador

12. MAIDEN NAME OF MOTHER Victoria Herrera

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Cadiz
(STATE OR COUNTRY) Spain

14. INFORMANT (Address) John Gibson Isabel
Eldon, Mo.

15. FILED 2-14, 1930 Belle Haynes
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 9 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 1st, 1930, to Feb 9, 1930, that I last saw h. or alive on Feb 9, 1930, and that death occurred, on the date stated above, at 8:30 Am.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia, Bilateral
14-2-30
11-11-30 (duration) yrs. mos. 9 ds.
CONTRIBUTORY Influenza - child birth
(SECONDARY) (duration) yrs. mos. 5 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF 2-9-30
(Premature child birth)

WHAT TEST CONFIRMED DIAGNOSIS clinical
(Signed) E. B. Shelton, M. D.

. 19 (Address) E. B. Shelton

*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 Eldon Cem. Eldon Mo. DATE OF BURIAL Feb 11 1930

20. UNDERTAKER W. A. Phillips ADDRESS Eldon, Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD
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.

SEP 26 1947