

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
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

11993

PLACE OF DEATH

County Cass
Township Grand River
City Harrisonville (No. 1)

Registration District No. 156
Primary Registration District No. 11993

File No. _____
Registered No. 21
St. _____ Ward _____

2. FULL NAME Eliza F. Ament
(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>E. P. Ament</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>July 15-1850</u>		
7. AGE <u>79</u>	YEARS <u>8</u>	MONTHS <u>27</u>
		DAYS <u>27</u>
		IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Home-maker</u> (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) Virginia

PARENTS	10. NAME OF FATHER <u>John Shingleton</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Virginia</u>
	12. MAIDEN NAME OF MOTHER <u>Katherine Hare</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Virginia</u>

14. INFORMANT <u>Dora H. Cronley</u> (Address) <u>524 Clay St. Harrisonville Mo.</u>
15. FILED <u>4/13/30</u> <u>11:30</u> REGISTRAR <u>Dr. Lott</u>

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 12 1930
17. HEREBY CERTIFY, That I attended deceased from April 12, 1930, to April 12, 1930, that I last saw him alive on April 12, 1930, and that death occurred, on the date stated above, at 6:10 A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Nephritis
with Resacine Coma
131 (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) 89.5
1290 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

8. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) J. W. Scott, M. D.
, 19 (Address) Harrisonville 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 <u>Burford Cemetery</u>	DATE OF BURIAL <u>4/13 1930</u>
20. UNDERTAKER <u>Rosenburger Bros & Co.</u>	ADDRESS <u>Harrisonville Mo.</u>

