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

Do not use this space.

19990

1. PLACE OF DEATH
County Macon. Registration District No. 528
Township [illegible] Primary Registration District No. 4314
City Callao, (No. ..... St. ..... Ward)
File No. ..... Registered No. .....

2. FULL NAME Mrs. Elizabeth Jane Autry.
(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	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 Frank Baker Autry

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 22 1847

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	84	7	29	

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) Livingston Co.
(STATE OR COUNTRY) New York.

PARENTS
10. NAME OF FATHER Patrick Dowling.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ireland.
12. MAIDEN NAME OF MOTHER Rachel Farley.
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ireland

14. INFORMANT Charles P. Johnson.
(Address) Callao Missouri

15. FILED 6/23, 1930 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 21 1930

17. I HEREBY CERTIFY, That I attended deceased from June 17, 1930, to June 21, 1930, that I last saw her alive on June 21, 1930, and that death occurred, on the date stated above, at 1:10 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Apoplexy.
(duration) ..... yrs. ..... mos. 4 ds.
CONTRIBUTORY (SECONDARY) Arteriosclerosis
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? Home
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Symptoms
(Signed) [signature], M. D.
6/23, 1930 (Address) Callao 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
Callao Cemetary	June 28 1930
20. UNDERTAKER G. A. Perry & Son	ADDRESS Callao

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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

1. PLACE OF DEATH
County Macon Registration District No. 828 File No.
Township Primary Registration District No. 4314 Registered No.
City Callao (No. ..... St. ..... Ward)

2. FULL NAME Elizabeth Jane Autry

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	W	Wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 22-1847

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
82	7	29	

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 8/8, 1930 W. W. Wardlaw
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 21 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

S-19990