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

Do not use this space.

22204

1. PLACE OF DEATH
County Carroll — Registration District No. 135 — File No.
Township — Primary Registration District No. 3010 — Registered No. 62
City Carrollton (No. 206 West Heidel St. 3rd Ward)

2. FULL NAME Elizabeth Stickel Brewer
(a) Residence. No. 206 W Heidel St., 3rd Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 5 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	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF E.B. Brewer

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8-1-1855

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	74	11	1	

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) Duquoin Ill
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Moses Stickel
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Virginia
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Acenith Reed
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ill
(STATE OR COUNTRY)

14. INFORMANT E B Brewer
(Address) Carrollton Mo

15. FILED 7-3, 1930 Mrs E E Farnham REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-2 1930

17. I HEREBY CERTIFY, That I attended deceased from 6/2/30, 19.., to 7/1/30, 1930 that I last saw her alive on 7/1, 19.. and that death occurred, on the date stated above, at 12:05 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia 18 hrs
Hypostatic 1 hr
She fell - accidental
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (SECONDARY) Fracture left femur
(duration) yrs. mos. 6 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?
(Signed) William G. Atwood M. D.
7/2, 1930 (Address) Carrollton 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 Oak Hill Cemetery — DATE OF BURIAL 7/3 1930

20. UNDERTAKER Willis Funeral Home — ADDRESS Carrollton Mo

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: Carroll — Registration District No.: 135 — File No.: 22204
Township: — Primary Registration District No.: 3010 — Registered No.:
City: Carrollton (No. , St. Ward)

2. FULL NAME: Elizabeth Stickel Brewer

(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: 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)

7. AGE — YEARS — MONTHS — DAYS — 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 July 3, 1930 Mrs E E Farrell
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 2 19 30

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:
Hypostatic Pneumonia, accidental fall. She had been sick + got up + went to the kitchen + in her
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) fracture left femur
weakened condition she
(duration) yrs. mos. ds.
18. WHERE WAS DISEASE CONTRACTED got her balance + fell with the
IF NOT AT PLACE OF DEATH? above result
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

1835

FEE FOR RECEIVES A FEE FOR RECORDS UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S - 22204