

SEP 26 1930

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

Do not use this space.

27681

1. PLACE OF DEATH

County *Reynolds*
Township *Wells*
City *Waverly Mo.*

Registration District No. *1108*
Primary Registration District No. *15783*

File No. _____
Registered No. *1*
St. _____ Ward) _____

2. FULL NAME

Elizabeth Piles

(a) Residence. No. _____ St. _____ Ward. _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. *7* 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

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

J. B. Piles

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

4/22/1859

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<i>71</i>	<i>3</i>	<i>10</i>	<i>3</i>

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)

(STATE OR COUNTRY) *Callington Mo.*

PARENTS

10. NAME OF FATHER

Osall Copeland

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *Reynolds Co., Mo.*

12. MAIDEN NAME OF MOTHER

Evaline Hanger

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *Reynolds Co., Mo.*

14. INFORMANT

(Address) *J. B. Piles
Waverly Mo.*

15. FILED

8/2 1930

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *8/2 1930*

17. I HEREBY CERTIFY, That I attended deceased from *6/22* 19*30* to *Aug 2* 19*30*
that I last saw *her* alive on *Aug 2* 19*30* and that death occurred, on the date stated above, at *10:15* a. m. *1930*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Cancer of sigmoid
intestine*
4 5
(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? *No* DATE OF _____

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS *Phys Diagnosis*

(Signed) *J. B. Piles* M. D.

, 19 (Address) *Waverly 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

Pilesburg

DATE OF BURIAL

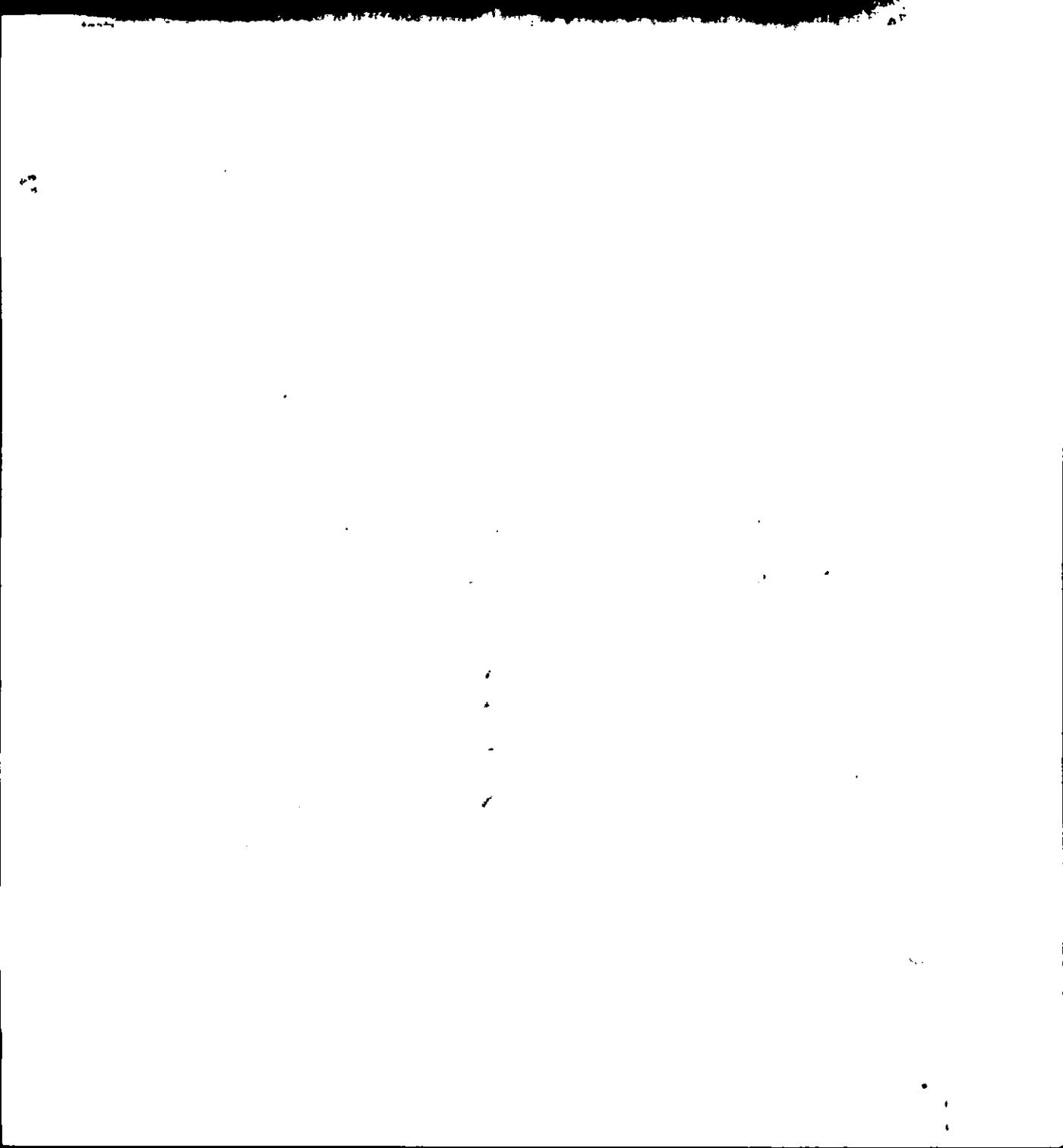
8/3 1930

20. UNDERTAKER

Light Under Co, Waverly Mo

ADDRESS

CAUSE OF DEATH IN PHRASES COMMONLY USED IN THE U. S.—Every item to be properly classified.



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Reynolds
Township Webb
City..... (No..... Ward)

Registration District No. 1108
Primary Registration District No. 5983

File No.....
Registered No.....
St. Ward)

2. FULL NAME

Elizabeth Giles

(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 | 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..... (duration)..... yrs..... mos..... ds.
(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)

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 8/2 1930 E. B. Giles M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/2 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

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NO...IVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
N. B.—Every item of information should be correctly written. If a mistake is made, the certificate should be cancelled. A new one should be prepared and filed. The original of the certificate should be retained in the office of the Registrar.

SUPPLEMENTARY

1930

27681