

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.

FEB 23 1931

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

Do not use this space.

35753-B

1. PLACE OF DEATH

County Douglas Registration District No. 1061  
Township M. Allen Primary Registration District No. 5385  
City near Bryant (No. ....) St. .... Ward

2. FULL NAME

Jennie Selsor  
(a) Residence No. RFD St. .... Ward. ....  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred 25 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 white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wm H Selsor  
6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 24 1854  
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .... hrs. or .... min.  
76 3 17

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

9. BIRTHPLACE (CITY OR TOWN) Grant Co. Indiana  
(STATE OR COUNTRY)

10. NAME OF FATHER Joel Green  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ohio  
(STATE OR COUNTRY)  
12. MAIDEN NAME OF MOTHER E. Elizabeth Schley  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Virginia  
(STATE OR COUNTRY)

14. INFORMANT W. J. Green  
(Address) Alba Missouri

15. FILE Jan 20, 1931 W. S. Mc Crite  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) November 11 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 ..... 1 15 P m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Seriously ill  
old age  
no doctor attended  
162 (duration) yrs. mos. ds.  
CONTRIBUTORY (SECONDARY) 164 (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) W. S. Mc Crite Local Registrar  
, 19 (Address) Bryant 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 Carthage Mo DATE OF BURIAL 19

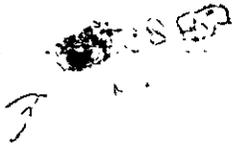
20. UNDERTAKER F. A. Stuffs ADDRESS Manfield Mo

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**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 Douglas Registration District No. 1061 File No. ....  
 Township Miller Primary Registration District No. 2-383- Registered No. ....  
 City (No. ....) St. .... Ward)

2. FULL NAME Jennie Nelson  
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**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) July 24, 1854

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
76 3 17

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

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 11 1920

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., 19....., to ..... 19....., 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:  
Senility  
old age  
No doctor attended  
 (duration)..... yrs. .... mos. .... da.

CONTRIBUTORY (SECONDARY) 16  
 (duration)..... yrs. .... mos. .... da.

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)

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

10. NAME OF FATHER Sam

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

12. MAIDEN NAME OF MOTHER Scholy

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

14. INFORMANT (Address) 1

15. FILED Jan 20 1931 G. S. Mc Crite REGISTRAR

\*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  
Carthage Mo. Nov 14 1930

20. UNDERTAKER ADDRESS  
F. A. Steffe Manassas Mo.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW  
 Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state DEATH in plain text so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

5-35753-B