

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

Do not use this space.

**1. PLACE OF DEATH**

County Jackson  
Township Blue  
City Leeds (No. General Hospital #2 St. \_\_\_\_\_ Ward)

Registration District No. 395  
Primary Registration District No. \_\_\_\_\_

File No. 39691  
Registered No. 5286

**2. FULL NAME**

(a) Residence. No. 1324 Lydial St. \_\_\_\_\_ 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 Female 4. COLOR OR RACE negro. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5-24-1915

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>15</u>	<u>7</u>	<u>0</u>	

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

9. BIRTHPLACE (CITY OR TOWN) St. Louis  
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Alberta Ellis

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Washington  
(STATE OR COUNTRY) \_\_\_\_\_

12. MAIDEN NAME OF MOTHER Elder Roberta

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Texas  
(STATE OR COUNTRY) \_\_\_\_\_

14. INFORMANT N.C. T. R. Hospital  
(Address) Leeds, Mo.

15. FILED 1/31/30 M. M. Crowe REGISTRAR  
Asst

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-24-1930

17. I HEREBY CERTIFY, That I attended deceased from 9-28-, 1930, to 12-24-, 1930, that I last saw h. ev. alive on 12-24-, 1930, and that death occurred, on the date stated above, at 1245 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Acute Pulmonary Tuberculosis  
23A  
(duration) 0 yrs. 9 mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) none  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED unknown  
IF NOT AT PLACE OF DEATH, \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS Clinical Laboratory  
(Signed) Edwin H. Hester, M. D.

DE 31, 1930 (Address) 1830 Vine St K.C. 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 Blue Ridge DATE OF BURIAL Jan 3, 1931

20. UNDERTAKER Adkins Bros ADDRESS 2000 E 12th

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

