

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

Do not use this space.

42

PLACE OF DEATH

County Atchison
Township Clay
City Atchison (No. 19)

Registration District No. 19
Primary Registration District No. 5025

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Bess Clara Liess

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

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Smith Liess</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Sept 30 - 1906</u>		
7. AGE YEARS <u>24</u>	MONTHS <u>3</u>	DAYS <u>6</u>
If LESS than 1 day, _____ hrs. or _____ min.		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>House Wife</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>" "</u> (c) Name of employer _____		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 6th 1931

17. I HEREBY CERTIFY, That I attended deceased from Dec 29th 1930 to Jan 6th 1931 that I last saw him alive on Jan 5th 1931, and that death occurred, on the date stated above, at 2 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS
Pneumonia (lobar) accompanied by pleurisy and emphysema
(duration) 108 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 108
(duration) 108 yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Atchison Mo

10. NAME OF FATHER Edward Cooper

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

12. MAIDEN NAME OF MOTHER Mary Cooper

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

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) William R. Stuckland M. D.
Jan 7th 1931 (Address) Rockport, 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.

14. INFORMANT Mrs Mary Cooper
(Address) Langdon Mo

15. FILED 1-7-31 May J. Chamberlain
REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Hunter Cemetery DATE OF BURIAL Jan 8 1931

20. UNDERTAKER W. E. Burton ADDRESS Rockport

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.

10 1931

