

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

Do not use this space.

25283

1. PLACE OF DEATH

County Jackson Registration District No. 383 File No. _____
 Township Kaw Primary Registration District No. 1091 Registered No. 3780
 City Kansas City Mo Trinity Lutheran St. _____ Ward _____

2. FULL NAME

Hester Elga Selza St. _____ Ward Princeton Mo
 (a) Residence. No. _____ (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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF James Elga

7. DATE OF BIRTH (MONTH, DAY AND YEAR) July 20, 1885

7. AGE YEARS 46 MONTHS _____ DAY 11 If LESS than 1 day, hrs. _____ or min. _____

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) Meriden Mo.
 (STATE OR COUNTRY)

10. NAME OF FATHER Wm Gaul

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

12. MAIDEN NAME OF MOTHER Mione

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

14. INFORMANT James Elga
 (Address) Princeton Mo

15. FILED 7/31 1931 M. M. Crowe REGISTRAR
Ans

PARENTS

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-31-1931

17. I HEREBY CERTIFY, That I attended deceased from July-27 1931 to July-31 1931
 that I last saw her alive on July 31 1931, and that death occurred, on the date stated above, at 8:05 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Uterine Myo Fibroma
99A (duration) 1 yrs. mos. ds.
 CONTRIBUTORY Myocarditis
 (SECONDARY) (duration) ? yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH Princeton Mo

19. DID AN OPERATION PRECEDE DEATH? Yes DATE OF 7-27-31

20. WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS Clinical
 (Signed) Ray U. Strawn M. D.

7/31, 1931 (Address) 6247 Brookside
 *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.

21. PLACE OF BYRIAL, CREMATION, OR REMOVAL Princeton Mo DATE OF BURIAL Aug 1931

22. UNDERTAKER Nail Moss ADDRESS Princeton Mo

Exact statement of OCCUPATION is very important.

It may be properly classified.

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County..... Registration District No..... File No.....
Township..... Primary Registration District No..... Registered No. 3187
City..... (No. Prinity Hoop)..... St. Ward)

2. FULL NAME

Hester Elza J
(a) Residence. No. St. Ward. ; Princeton Mo.
(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. dg.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-31-1931

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

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.

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Intermittent myxosarcoma
of Benzoin

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

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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

CONTRIBUTORY (SECONDARY) myocarditis acute
(duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

10. NAME OF FATHER

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

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

WAS THERE AN AUTOPSY.....

12. MAIDEN NAME OF MOTHER.....

WHAT TEST CONFIRMED DIAGNOSIS.....

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

(Signed)..... Robert J. ... M. D.
812, 1931, (Address) 6247 Brookside

14. INFORMANT (Address)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

15. FILED 7/31 1931 M.M. Keroue REGISTRAR

20. UNDERTAKER ADDRESS 19

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.