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

Do not use this space.

25671

1. PLACE OF DEATH
County Mississippi — Registration District No. 566 — File No.
Township Township — Primary Registration District No. 3030 — Registered No. 69
City Charleston (No. ..... St. ..... Ward)

2. FULL NAME Isabel Black

(a) Residence. No. ..... St., ... Ward. ..... (If nonresident, give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

AUG 28 1931

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 4 1855

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
76	2	19	

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

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

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)

14. INFORMANT H. E. Black
(Address) Charleston Mo.

15. FILED July 23rd, 1931 F. A. Vernon REGISTRAR

MEDICAL CERTIFICATE OF DEATH 2 6 A.M.

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/23 1931

17. I HEREBY CERTIFY, That I attended deceased from 7/16/31, 19....., to 7/23/31, 19..... that I last saw h. E.R. alive on 7/16, 1931, and that death occurred, on the date stated above, at 6:00 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of Liver
46E
162
at least (duration) ..... yrs. 5 mos. ..... ds.

CONTRIBUTORY (SECONDARY) Debility & Senility
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH —
O DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical Symptoms
(Signed) E. Chas. Colwing M. D.
, 19 (Address) Charleston 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 I.O.O.F. — DATE OF BURIAL 7-24 1931

20. UNDERTAKER Fair Und Co. — ADDRESS Charleston Mo.

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.

[redacted] & [redacted]

Dr. Holwing