

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

Do not use this space.

27371

1. PLACE OF DEATH

County North
Township Stetchell
City Grant City (No. 2)

Registration District No. 903
Primary Registration District No. 45-45-

File No. _____
Registered No. 18
St. _____ Ward _____

2. FULL NAME

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

Length of residence in city or town where death occurred yrs. 6 mos. 0 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Dr. G. E. Elley

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 24, 1842

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. _____ min.
88 9 1

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Lined with
(b) General nature of industry, business, or establishment in which employed (or employer) Grandson
(c) Name of employer _____

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

10. NAME OF FATHER William Nickel

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Don't know
(STATE OR COUNTRY) Kentucky

12. MAIDEN NAME OF MOTHER Martha Custer

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

14. INFORMANT Mrs. Vera Elley
(Address) Grant City

15. FILED 7/25 1931 John A. Adams
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 25 1931

17. I HEREBY CERTIFY, That I attended deceased from May 10, 1931, to July 25, 1931
that I last saw her alive on July 24, 1931, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Emphysema - right
side of neck
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 536
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

1) DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Specified Findings
(Signed) J. P. Bell, M. D.

(Address) Grant City

*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 Grant City Cemetery DATE OF BURIAL 7/26 1931

20. UNDERTAKER Arch C. Duple ADDRESS Grant City

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

K. 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.

AUG 20 1931

7