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

Do not use this space.

30451

1. PLACE OF DEATH

County Atchinson — Registration District No. 22 — File No.

Township Lincoln. — Primary Registration District No. 5831 — Registered No.

City ..... (No. ..... St. ..... Ward)

2. FULL NAME Eliza Jane Daniels.

(a) Residence. No. ..... St., ... Ward. .....
(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.

OCT 22 1931

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March, 4, ~~1931~~ 1853

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ... hrs. or ..... min.
	78	6	26	

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

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

PARENTS

10. NAME OF FATHER Squire Roberts.

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

12. MAIDEN NAME OF MOTHER Sarah Caudle.

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

14. INFORMANT Mrs. Fannie Bain.
(Address) Westboro, Missouri.

15. FILED ....., 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 30th 1931

17. I HEREBY CERTIFY, That I attended deceased from Nov 10th, 1930, to Sept 30, 1931 that I last saw her alive on Sept 29 1931 and that death occurred, on the date stated above, at 1:30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Senility accompanied by Chronic Myocarditis
93C
56E
16½ (duration) 6 yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Place of Death

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Nonalysis EX

(Signed) E B Kenner M. D.

, 19 (Address) Westboro 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	DATE OF BURIAL
Center Grove	Westboro Mo.
20. UNDERTAKER	**ADDRESS**
Westboro, Missouri	Oct. 1st, 1931

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.

WHITE PLANET, WITH UNFADING INK—THIS IS APPLICABLE MANENT RECORD

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County: Atchison — Registration District No.: 22 — File No.:
Township: Lincoln — Primary Registration District No.: 3031 — Registered No.:
City: (No. , St. Ward)

2. FULL NAME: Eliza Jane Daniels
(a) Residence. No. St., Ward.
(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: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): wid

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

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

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

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

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

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

14. INFORMANT
(Address)

15. FILED Oct 1, 1931 — G. W. Scott, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 9/20 19 31

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.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(duration) yrs. mos. ds.

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

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) , M. D
, 19 (Address)

*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 — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

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.

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

Sign

S-30451