

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

Do not use this space.

9439

1. PLACE OF DEATH

County Madison
Township Madison
City Madison (No. 6)

Registration District No. 674
Primary Registration District No. 4375

File No. _____
Registered No. 3
St. _____ Ward _____

2. FULL NAME

Franklin Ira Elmsted
(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred 30 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 Male **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 24 - 1896

7. AGE YEARS 25 MONTHS 6 DAYS 9
IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Hotel Landlord
(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) Jameson, Ohio

10. NAME OF FATHER James H. Elmsted

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

12. MAIDEN NAME OF MOTHER Mary Ellen Stiffle

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

14. INFORMANT Mary Pauline Estes
(Address) Pickering Mo.

15. FILED 7/4 1937 R. H. Payne REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 2 1937

17. I HEREBY CERTIFY, That I attended deceased from Nov 1st 1931 to March 2 1937
that I last saw him alive on 3/2 1937 and that death occurred, on the date stated above, at 3:55 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocardial disease of heart
930 (duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 1310 (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

20. WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) [Signature] M. D.

314 1937 (Address) Hopkins W.
*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 Hotel **DATE OF BURIAL** Mar 11 1937

20. UNDERTAKER [Signature] **ADDRESS** [Address]

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.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

APR 3 8 1937

1222

5