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

Do not use this space.

9832

1. PLACE OF DEATH
94 County St Francois
2 Township Perry
6 City Bonne Terre (No. ..... St. ..... Ward)
Hospital Irene J Stevens

Registration District No. 775
Primary Registration District No. 6020

File No. .....
Registered No. 14

2. FULL NAME .....
(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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: R Lowell Stevens

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Nov. 18, 1908

7. AGE: Years 23 | Months 3 | Days 22 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Wife 13
(b) General nature of industry, business, or establishment in which employed (or employer): 235
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): St Francois Co. Mo.

PARENTS
10. NAME OF FATHER: Ed. Elser
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): St Francois Co. Mo
12. MAIDEN NAME OF MOTHER: Mary Nersen
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): St Francois Co. Mo

14. INFORMANT: Ed Elser
(Address) R 6 Farmington Mo

15. FILED 3/11 1932 T A Son REGISTRAR

MEDICAL CERTIFICATE OF DEATH

4

16. DATE OF DEATH (MONTH, DAY AND YEAR): 3/10 1932

17. I HEREBY CERTIFY, That I attended deceased from ....., 19.... to ....., 19.... that I last saw her alive on 3/10, 1932, and that death occurred, on the date stated above, at 1:30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
General Peritonitis with Abscess ~~second~~ following Uterine Infection
Secondary, Lung abscess
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): 139 (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Same
DID AN OPERATION PRECEDE DEATH? Yes DATE OF ..... (1)
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? Clin & Op Cont
(Signed) R Appalachy, M. D
3/11, 1932 (Address) Farmington 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: Odd F Cemetery Doe Run
DATE OF BURIAL: 3/12 1932

20. UNDERTAKER: Neidert Und Co
ADDRESS: Fyton Mo
Farmington

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.

APR 29 1932