

**BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

1. PLACE OF DEATH  
 38 County Kenyon Registration District No. 309 File No. 19194  
 1 Township Albany Primary Registration District No. 485 Registered No. 81  
 2 City Albany Mo No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 2. FULL NAME Elizabeth Jane Jeffries (Jeffries)  
 (a) Residence No. Rose Hospital, Albany Mo Ward \_\_\_\_\_ (If nonresident, give city or town and State)  
 (Usual place of abode) \_\_\_\_\_  
 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) married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ben Jeffries  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 21 - 1893  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
39 6 9  
 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) 233  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) mo

PARENTS  
 10. NAME OF FATHER W P McDaniel  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) mo  
 12. MAIDEN NAME OF MOTHER Rebecca McGeel  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) mo

14. INFORMANT Ben Jeffries  
 (Address) m. Fall mo

15. July 2, 1932 W. S. Masten  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-30-32 1932  
 17. I HEREBY CERTIFY, That I attended deceased from 6-30- 1932, to 6-30- 1932 that I last saw h. a. r. alive on 6-30- 1932, and that death occurred, on the date stated above, at 2:42 p. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Diabetes mellitus  
39 57 (duration) yrs. mos. ds.  
 CONTRIBUTORY (SECONDARY) Coma  
 (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

20. WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS clin  
 (Signed) Frank H. Rose M. D.  
6-30- 1932 (Address) Albany, 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 Hoatal Cemetery DATE OF BURIAL 7-2-32

20. UNDERTAKER Edw. Schrammer Parsonsburg mo ADDRESS \_\_\_\_\_

1932  
339  

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**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 Century  
Township \_\_\_\_\_  
City Albany (No. \_\_\_\_\_)

Registration District No. 309  
Primary Registration District No. 4185

File No. \_\_\_\_\_  
Registered No. 31  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Elizabeth Jane Jeppies  
St. \_\_\_\_\_ Ward \_\_\_\_\_

(a) Residence, No. \_\_\_\_\_ (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**

**MEDICAL CERTIFICATE OF DEATH**

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 30, 1932

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

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, to \_\_\_\_\_, 19.....

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 21-1893

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19..... Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
38 6 9

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_  
11. Total time (years) spent in this occupation \_\_\_\_\_

Other contributory causes of importance:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

13. NAME \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19.....  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

Specify whether injury occurred in industry, in home, or in public place.  
Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19.....

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_

20. FILED Aug 6, 1932 W. J. Martin Registrar

(Signed) \_\_\_\_\_, M. D.  
(Address) \_\_\_\_\_

**SUPPLEMENTARY**

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 CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

