

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

Do not use this space.

108

28289

1. PLACE OF DEATH

County Veranda
Township Howardsville
City Veranda

Registration District No. 874
Primary Registration District No. 6157

File No.
Registered No.
St. Ward)

2. FULL NAME

Elgie Endora Rush

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

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 12 - 1896

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
56 17

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) 235
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Ray County, Mo.
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Chas. Hinds
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ray Co., Mo.
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Rachel B. Lee
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ray Co., Mo.
(STATE OR COUNTRY)

14. INFORMANT (Address) Frank M. Perry
Los Angeles - Cal.

15. FILED 9. 5. 1932 R. C. Carter
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-29-1932

17. I HEREBY CERTIFY, That I attended deceased from 8-16-1932 to 8-29-1932, 1932
that I last saw her alive on 8-29-1932, and that death occurred, on the date stated above, at 9:10 P.M.

THE CAUSE OF DEATH WAS AS FOLLOWS:
abscess of spleen

18. CONTRIBUTORY (SECONDARY) 31
(duration) yrs. mos. da.
72 H
(duration) 1 yrs. mos. da.

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

18. DID AN OPERATION PRECEDE DEATH..... DATE OF.....
WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) W. C. Carter, M. D.
, 19 (Address) Howardsville, 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 Forest Hill N. City, Mo DATE OF BURIAL 8-31 1932

20. UNDERTAKER Perry Bros ADDRESS Howardsville, Mo

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.

OCT 30 1932

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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 Bernon Registration District No. 874
Township Monmouth Primary Registration District No. 6151
City (No) St. _____ Ward _____

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

2. FULL NAME

Elgie Endora Rush
(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 (to W if this word)

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. 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

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

13. NAME

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

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)

20. FILED 9-5-1932 H. C. Carter Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 29, 1932

22. I HEREBY CERTIFY, That I attended deceased from _____, to _____, 19__

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

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

Abscess, spleen tuberculous Date of onset _____

Other contributory causes of importance:

BBE

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

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)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

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

(Signed) _____, M. D.

(Address) _____

Item of information should be carefully checked. AGE should be stated EXACTLY. PHYSICIAN should be certified. Exact statement of OCCUPATION should be given. THIS SHALL NOT RECEIVE A FEE FOR 3 UNTIL THEY ARE COMPLETE AS PRE

SUPPLEMENTARY

S-28289