

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

Do not use this space.

**22055**

**1. PLACE OF DEATH**

103 County Shelby  
5 Township Black Creek  
3 City Shelbyville (No. ....)

Registration District No. 831  
Primary Registration District No. 4504

File No. ....  
Registered No. ....  
St. .... Ward)

**2. FULL NAME**

Mary Elizabeth Todd

(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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 17, 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
73 10 18

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. none  
(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) Ladysburg, Mo.

10. NAME OF FATHER Rev. Jos. S. Todd

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

12. MAIDEN NAME OF MOTHER Mary E. Miller

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

14. INFORMANT (Address) J. A. Danner Shelbyville, Mo.

15. FILED June 7, 1933 Emmett A. Houston REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 5, 1933

17. I HEREBY CERTIFY, That I attended deceased from May 29, 1933 to June 5, 1933 that I last saw him alive on June 5, 1933, and that death occurred, on the date stated above, at 9:50 p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

broncho pneumonia  
20 H  
10 A  
73  
(duration) yrs. mos. 6 ds.

CONTRIBUTORY (SECONDARY) 9. B. of lungs  
about 4 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 symptoms  
(Signed) H. G. Smith, M.D.  
, 19 (Address) Shelbyville, 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.

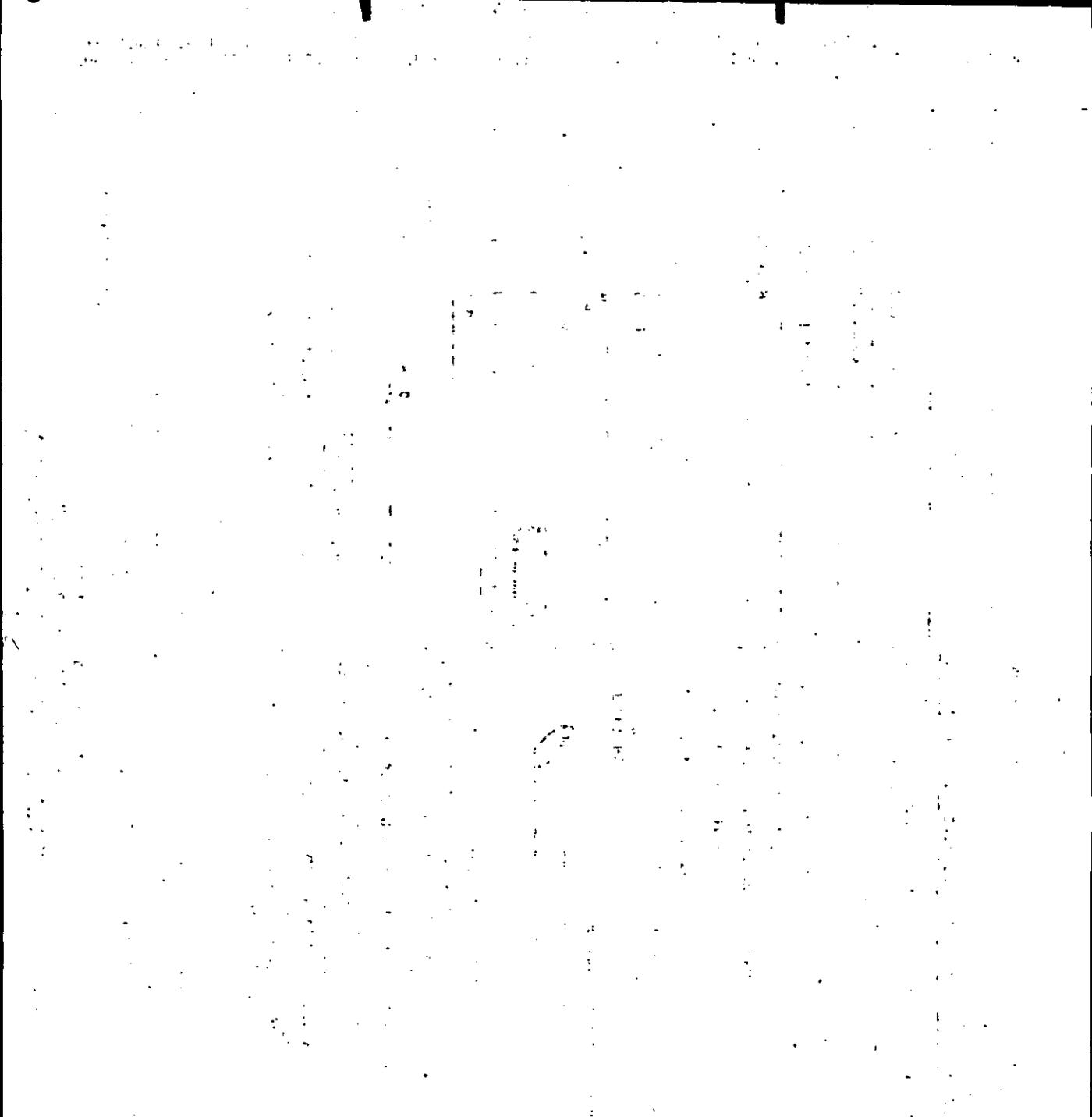
19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL  
I.O.O.F. Cemetery June 7, 1933

20. UNDERTAKER ADDRESS  
J.W. Thompson Son Shelbyville, Mo.

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.

JUL 22 1933



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