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

Do not use this space.

File No. 32706

Registered No. 40

1. PLACE OF DEATH

County: Franklin

Township: Central

City: ..... (No. ..... P. ..... St. ..... Ward)

Registration District No. 294

Primary Registration District No. 5409 B

2. FULL NAME: Elsie Meeks

(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.

NOV 10 1933

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): S

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: —

6. DATE OF BIRTH (MONTH, DAY AND YEAR): V-27-1933

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	4	16	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Central Twp.
(STATE OR COUNTRY) Franklin Mo.

PARENTS

10. NAME OF FATHER: Jim Meeks

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Franklin Co. Mo.

12. MAIDEN NAME OF MOTHER: Tyger

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

14. INFORMANT: Jim Meeks
(Address) Sullivan Mo.

15. FILED 10/16, 1933. N. H. Weckenmann
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-13-1933

17. I HEREBY CERTIFY That I attended deceased from 9/28, 1933, to 10-13-1933, that I last saw h. alive on 9-28-1933 and that death occurred, on the date stated above, at 9 30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Measles

154

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Lack of care

(duration) ..... yrs. ..... mos. ..... ds.

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

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) W. E. Mitchell, M. D.

10/14, 1933 (Address) St. Louis 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: New Bethel Cemetery

DATE OF BURIAL: 10/16 1933

20. UNDERTAKER: Gunsaulus

ADDRESS: Sullivan 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.