LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

MAR 24 1934

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

Do not use this space.

File No. 5913
Registered No. 10

1. PLACE OF DEATH
County Nodaway
Township Palk
City Hospital (No. ..... St. ..... Ward)
Registration District No. 6251
Primary Registration District No. 3031

2. FULL NAME Elizabeth Elsworth
(a) Residence, No. ..... St., ... 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 Female
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word) widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 6 - 1868
7. AGE YEARS 65 - MONTHS 7 DAYS 26 23 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
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) Blondail Ill

FATHER
13. NAME John Elizabeth Terrell
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Delia Price (9)

MOTHER
15. MAIDEN NAME Virginia
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) Mrs W L Roads
18. BURIAL, CREMATION, OR REMOVAL Ravenwood
PLACE Feb 3 DATE 1934
19. UNDERTAKER (ADDRESS) Newton Long
20. FILED Feb 2 1934 Mamie E Clardy Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 1, 1934
22. I HEREBY CERTIFY, That I attended deceased from January 17, 1934, to February 2, 1934
I last saw her alive on Feb 1, 1934. Death is said to have occurred on the date stated above, at 1 a m.
The principal cause of death and related causes of importance were as follows:
acute Paralysis Agitans. Date of onset
Other contributory causes of importance:
Name of operation ✓ Date of ✓
What test confirmed diagnosis? ✓ Was there an autopsy? No
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? No
If so, specify ✓
(Signed) Chas. T. Bell, M. D.
(Address) Maryville, Mo.

87B

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

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1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No.....

City..... (No..... , ... St. .....Ward)

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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the 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.

OCCUPATION

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)

FATHER

13. NAME .

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

MOTHER

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....., 19..... .....
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) , 19

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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

	Date of onse
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.....	.....
.....	.....
.....	.....
Other contributory causes of importance:	
.....	.....
.....	.....
.....	.....

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).....