

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

Do not use this space.

1378
15977

1. PLACE OF DEATH

County Jackson Registration District No. 309
 Township Texas Primary Registration District No. 1002
 City H. C. Mo (No. 5734, Wabash) St. Ward

File No. _____

Registered No. 2346

2. FULL NAME

Elizabeth Lee Huston
 (a) Residence, No. 5734 Wabash St., _____ Ward. _____
 (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 Fe 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb - 1 - 1887

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
57 3 24

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housework

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) Kearney Mo

13. NAME A. O. Huston

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

15. MAIDEN NAME Susan Childs

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana Mo

17. INFORMANT Miss George Ann Huston (ADDRESS) 5734 Wabash

18. BURIAL, CREMATION, OR REMOVAL PLACE Wm. Wash DATE 5-28-34

19. UNDERTAKER Mrs. C. L. Foster (ADDRESS) 918 Broadway, av

20. FILED May 28 1934 M. M. Cowe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May - 25 - 34

22. I John D. [Signature] DO hereby certify that I attended deceased from _____, 19____.

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

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

Chronic Myocarditis
Chronic Myocarditis
151

Other contributory causes of importance: 930 no 13

Name of operation _____ Date of _____

What test confirmed diagnosis? Culture Was there an autopsy? _____

23. If death was due to external cause (injury), 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) [Signature], M. D.

(Address) [Signature]

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 important.

NOV 1 1934

