

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

Do not use this space.

1. PLACE OF DEATH

County De Kalb Co. Registration District No. 259
Township Shannon Primary Registration District No. 4156
City Amity (No. P.O. # 2 Amity)

File No. 19971
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Elizabeth H. Mason
(a) Residence, No. Amity, Ind. St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 12 1849

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
84 9 11

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

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) Canada

13. NAME John Hinkle

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS) T. J. Mason
Amity, Ind.

18. BURIAL, CREMATION, OR REMOVAL PLACE Amity Cem. DATE 6/5 34

19. UNDERTAKER (ADDRESS) Atorney Funeral Home
at Amity, Ind.

20. FILED 6/6 1934 Mrs. Nellie Gibson
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 3 1934

22. I HEREBY CERTIFY, That I attended deceased from June 12 33 to June 3 34

Last saw her alive on June 2nd 34 Death is said

to have occurred on the date stated above, at 1:15 A.M.

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

Chronic valvular heart disease Date of onset 10 yrs.

Bronchial asthma 20 yrs.

Other contributory causes of importance:

112 9 9 A

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 _____

(Signature) Samuel Johnson, M. D.

(Address) Springville, 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. JUN 21 1934

