

NOV 13 1934

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

Do not use this space.

1. PLACE OF DEATH

County GREENE Registration District No. 317
 Township REPUBLIC Primary Registration District No. 5436
 City (No. ,) St. Ward

File No. 35715

Registered No. _____

2. FULL NAME ELISHA DeBOARD

(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 MALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) JAN. 25th 1860

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
74 8 11

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. FARMER
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. FARM
 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) K.Y.13. NAME ARNER COLAND DeBOARD14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) K.Y.15. MAIDEN NAME SUSAN SEWELL16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) K.Y.17. INFORMANT Capt. E. A. Board
(ADDRESS) Republic Mo18. BURIAL, CREMATION, OR REMOVAL
PLACE Evergreen DATE 10/18 193419. UNDERTAKER R. P. Pysinger
(ADDRESS) Republic Mo20. FILED 10/18 1934 Mrs. Bertha N. Anco
(Registrar)

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-16 1934

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw him dead alive on 10-16, 1934 Death is said to have occurred on the date stated above, at 12³⁰ m.

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

Other contributory causes of importance: _____

Date of onset _____

Crushed Jaw - Skull
Fracture - Broken arm
and leg
 ✓ 10-16-34
 Other contributory causes of importance: _____

Name of operation _____ Date of _____

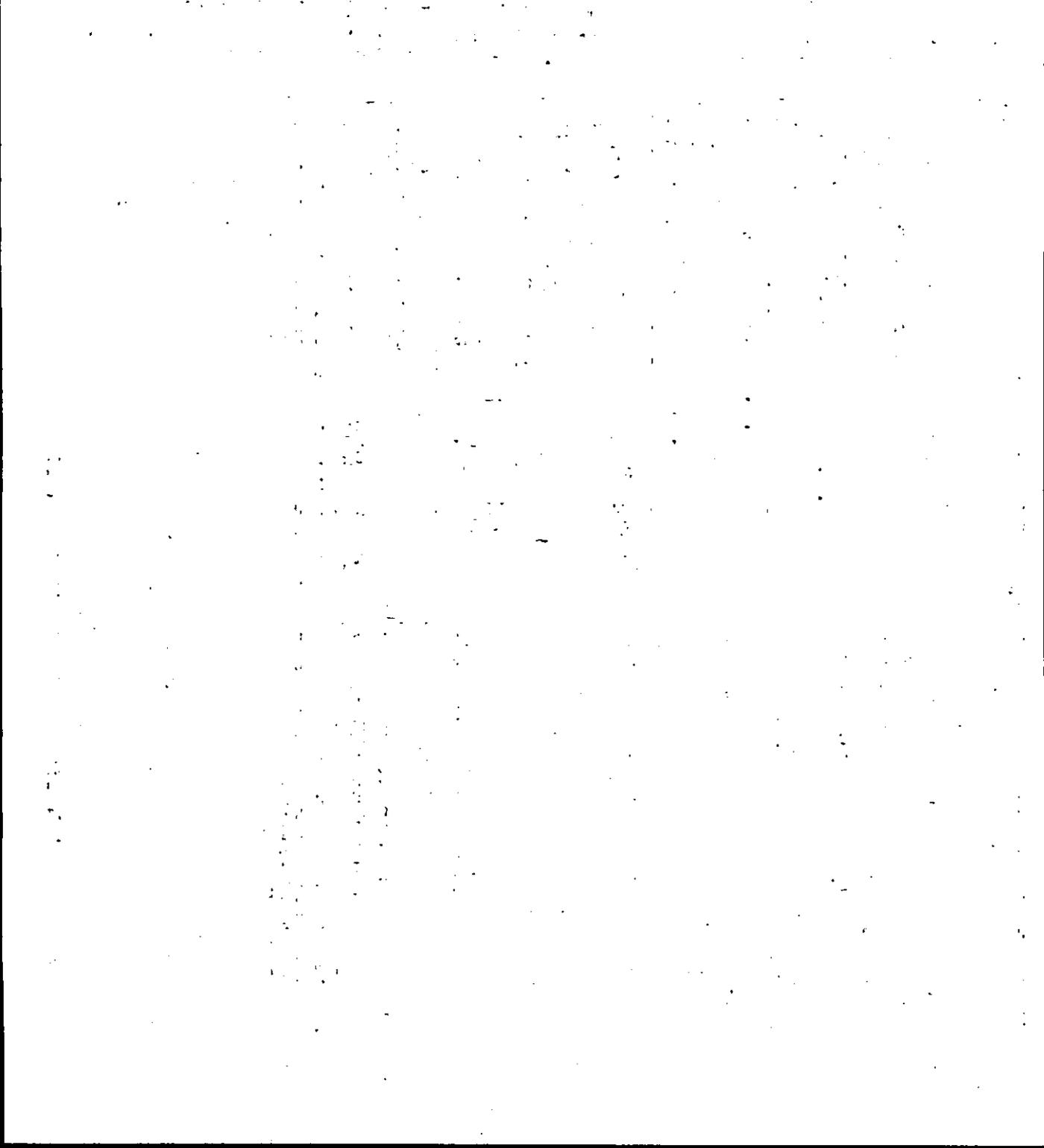
What test confirmed diagnosis? _____ Was there an autopsy? NO23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Accident Date of injury 10-16, 1934Where did injury occur? Republic Mo
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Struck by truck & right legNature of injury Street Fracture of leg24. Was disease or injury in any way related to occupation of deceased? NO

If so, specify _____

(Signed) Oliver A. Geary - coroner(Address) Springfield Mo



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Greene Registration District No. 317
Township Pepeblue Primary Registration District No. 5436
City Elisha de Rouse (No. _____) St. _____ Ward _____

File No. _____
Registered No. _____

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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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.
74 8 11

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) _____

13. NAME _____

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

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 Oct. 18, 1934 Mrs. Beatha Name Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 16, 1934

22. I HEREBY CERTIFY, That I attended deceased from _____, to _____, 19 _____

I last saw h. _____ alive on _____, 19 _____ Death is said to have occurred on the _____ above, at _____ m.

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

Cerebral case - Skull fractured Broken arm lacerated leg
In Automobile. Car stalled on crossing
Other contributory causes of importance: was a farmer

Date of onset _____

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) _____

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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